

**Treating and preventing HIV in the 'post-crisis' situation:
perspectives from the personal experience accounts of gay men with HIV**

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Thesis submitted for the degree of Doctor of Philosophy

Institute of Education

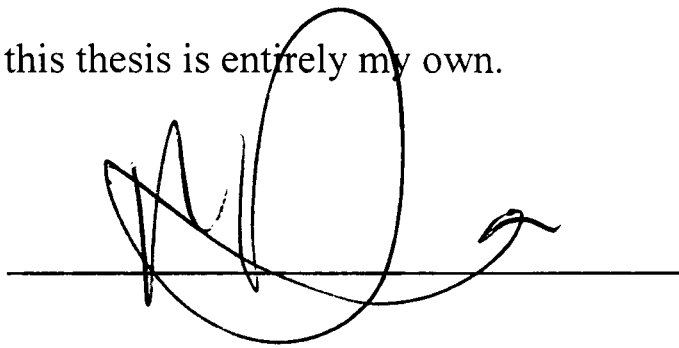
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2005



Declaration

I hereby declare that, except where explicit contribution is made, the work presented in this thesis is entirely my own.



19/4/2005

Word count (excluding appendices and reference list): 80581

Acknowledgements

I am grateful to the interviewees who contributed to this research.

My supervisor, Eva Gamarnikow was, as always, an endless source of advice and encouragement. I am particularly thankful for Eva's patience, her 'light touch' in supervision and for sharing her perspectives and experience with me.

I would like to acknowledge that some of the interviews done for this study were made possible through funding from the Medical Research Council. In addition, I would like to thank the investigators on the Medical Research Council study: John Imrie, Judith Stephenson, Oliver Davidson and Ian Williams (University College London) and Graham Hart (Medical Research Council). For assisting me with some of the practical arrangements for this study, I would like to thank the many academic and clinical staff at Royal Free and University College Medical School, University College London Hospitals and the Camden and Islington Primary Care Trust.

Abstract

The HIV epidemic has recently acquired a paradoxical quality connected with treatment and prevention. Since the mid 1990s, HIV treatment has improved life expectations, providing a sense of reduced seriousness of HIV infection or 'post-crisis'. But some hold that optimism about the effects of treatment leads to increases in risky sex that might transmit HIV, particularly among gay men with HIV. However there is little research about how gay men with HIV themselves account for this paradoxical post-crisis situation.

A thematic analysis of qualitative interviews with twenty-five gay men with HIV was used to address the gap in the literature and extend theory about treatment and sexual practice in the post-crisis situation. The analysis relies on governmentality and the risk society idea of manufactured uncertainty. It addresses the post-crisis situation in three dimensions: the meanings of post-crisis, identity in connection with treatment and prevention; and the implications of risk knowledge connected with aspects of treatment.

The interviewees did not endorse giving up HIV prevention because of effective treatment. The experience of taking HIV treatment seemed more ambivalent than implied by public constructions of post-crisis. Identity was subject to innovations in treatment and the imperatives of prevention, and some of the contradictions that arise in combination. Uncertainty and contest about aspects of treatment-related risk knowledge sponsored a question of risk management preference, informed by both technical and ethical judgements. Concerns over the sexual practice of gay men with HIV appear to be part of a general contest over the construction of 'reflexive treatment', in particular, setting the terms for the acceptable use of HIV treatment and its risk management potential.

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CHAPTER ONE: INTRODUCTION

Introduction

The HIV epidemic has recently taken on a paradoxical quality. For some time now in the affluent West, the effective treatment of HIV has improved the health of people with HIV, giving rise to a sense of the passing of the AIDS crisis, or as it is sometimes called, ‘post-crisis’. But at the same time, fears have emerged of continued or increasing HIV transmission related to treatment. It seems that the prospect of the end of AIDS has become a reason for the proliferation of HIV. Such fears have also sponsored a sharper focus on the sexual and HIV prevention practice of the treated, in particular, gay men with HIV. This thesis addresses the paradoxical quality of the post-crisis situation with reference to the personal experience accounts of gay men with HIV.

This chapter maps out the important features of the post-crisis situation and suggests a rationale for qualitative research on the subject. In particular, the sections that follow draw attention to critical perspectives and knowledge gaps connected with my own experience as a researcher-practitioner in HIV education, the methodological orientation of existing research and theoretical perspectives derived from the risk society and governmentality literature. The chapter also provides a brief description of the context for the project and how it was conducted. Last, I provide an overview of the thesis chapters.

The post-crisis situation

There are several aspects of the post-crisis situation relevant to this thesis. Post-crisis discourse about HIV prevention makes a connection between the improved capacity to treat HIV infection and the emergence of new forms of HIV transmission. This paradox

is informed by an assumption of a definite, medically-constituted watershed in the history of the epidemic. This watershed assumption has invaded accounts of the sexual practice of people with HIV and implies that in different ways, improvements in HIV treatment increase the risk of the sexual transmission of HIV. In addition, watershed thinking about the impact of treatment on sexual practice inspires a regulatory interest in the sexual practice of the people who have HIV, particularly gay men.

The advent of effective HIV treatment

At first the HIV epidemic caught us by surprise. In the early 1980s, when some gay men began to go to their doctors and hospitals with life-threatening pneumonia, experts were uncertain about what was happening. Now we know much more. As knowledge of the spread of the illness developed and different groups of people were affected, ways of naming the illness changed. Gay Related Immune Deficiency (GRID) turned into the Acquired Immune Deficiency Syndrome (AIDS). In the mid 1980s, virologists discovered a virus that seemed to cause AIDS and called it Human Immunodeficiency Virus (HIV). A blood test for HIV infection also became possible. Through this period, people affected by AIDS died in growing numbers. Communities affected by the health crisis mobilised to advise people how to avoid infection, to support those who had HIV and AIDS and advocate for the development of effective treatment. By the end of the 1980s, HIV was found throughout the world. It is estimated that world-wide, 39.4 million people now have the virus (UNAIDS/WHO, 2004). Gay men were among the first to be affected by HIV in the affluent west. In the UK, it is estimated that up to the end of June 2004, 12937 people have died of AIDS and 8847 of these people have been gay or other homosexually active men (Health Protection Agency, 2004).

However, advances in the treatment of HIV infection have changed the life prospects of many people with HIV. By the mid 1990s, clinicians began prescribing combinations of drugs each found to have a positive treatment effect on an aspect of HIV. In combination, and therefore by treating HIV infection in several ways at once, clinicians and patients found that health was more or less restored. As a consequence, deaths due to AIDS declined markedly. In the UK, deaths have declined from 1531 in 1994 to 266 in 2003 (Health Protection Agency, 2004).

But at the same time, concerns have developed about the growing risk of a secondary epidemic of both HIV transmission and drug-resistant HIV. Experts worry that because of treatment, at risk individuals are less concerned about HIV transmission and therefore less concerned about HIV prevention, leading to the continued spread of the virus. Experts have also begun to warn that through treatment itself, drug-resistant forms of HIV are developing and being spread among people affected by HIV, creating a vision of a truly post-crisis form of viral epidemic (Salomon et al., 2000). These forms of secondary HIV risk are seen to threaten the effective control of the epidemic because they undermine prevention and reduce the effectiveness of treatment.

Medical watershed

The idea that treatment might have the unwanted effect of increasing the risk of HIV transmission relies on an assumption of definite, medical watershed. This watershed assumption makes an analogy between the effects of treatment on the virus and the putative links between treatment and sexual practice. It implies that treatment influence the sexual and HIV prevention practice of people with HIV in much the same way it influences viral activity. Watershed discourse also informs accounts of the epidemic. For example, the Vancouver World AIDS Conference in 1996 is often used as a date

when things changed or as a significant moment in the course of the medical history of HIV (Holzemer, 1997). At this conference, research was announced that confirmed the efficacy of triple combination HIV treatment. Interestingly, it was also in 1996 that the notion of 'post-AIDS' was aired by social researchers in connection with HIV prevention (Dowsett & McInnes, 1996). These researchers used the term 'post-AIDS' to refer to the social and collective aspects of a dynamic HIV epidemic. In clinical practice, the term 'post-HAART' (Highly Active Anti-Retroviral Treatment) is used to refer to these changes in treatment practice (Anderson, 2004). Analysts have described the contemporary situation as "... community beyond crisis" drawing attention to how gay men engage with the changed circumstances of HIV risk (Rofes, 1998: 28). The advent of effective treatment and changes in the life expectations have suggested modifications in the ways that HIV is managed as a matter of public policy. Policy makers and researchers write about 'AIDS as a chronic disease', or the 'normalisation' of the epidemic (Rosenbrock et al., 2000; Siegel & Lekas, 2002).

Risky sex

As if to undo itself, post-crisis discourse about the effects of treatment in sexual practice mobilises a sense of reduced risk paired with, and providing impetus for, a sense of increased risk. It has been suggested that a sense of the reduced seriousness of HIV infection lessens motivation to avoid HIV. And in the imaginary of public health, effective treatment has removed one of the self-limiting features of the spread of viral epidemic, the death of the host.

Since, or even simultaneous with, declining death rates, research has concerned itself with the risk of increased spread of HIV related to aspects of HIV treatment. The most prominent theme in this research has been the idea that optimistic beliefs about

treatment lead people to abandon or place less emphasis on efforts to avoid HIV transmission (Dilley et al., 1997). There do seem to be increases in risky behaviour among people at risk of HIV infection and people with HIV. Accumulating statistical data suggest increases in self-reported risky sex among gay men (Dodds et al., 2000; Elford & Hart, 2003). Another aspect of such research is a focus on the presence of a sexually-active, treated population, mobilising an important shift in emphasis in HIV prevention rationality. HIV prevention has typically adopted the stance of encouraging all at risk people to avoid HIV infection by using condoms and sterile injecting equipment. But in the situation of treatable HIV, there seems to be a shift in emphasis to containing its spread from the growing numbers of people who already have it.

Gay men with HIV

Post-crisis is therefore connected with an increased regulatory interest in people with HIV. Research has come to focus on how well people take their medication and related self-care practices to ensure the best possible treatment effects. Policy makers and researchers have also called for interventions to increase altruistic conduct on the part of people with HIV regarding HIV prevention in sexual practice. Gay men figure prominently in this research and policy. Superficially, this attention is because in the affluent west, gay men remain one of the groups most affected by the epidemic (Health Protection Agency, 2003). But it also seems that there is a contest over responsible conduct involving gay men with HIV. For example, there has been both media and research inquiry about gay men who seek out sex that may transmit HIV. This contest discourse can be seen in a magazine article called *Bareback and Reckless*, which was also figured around an online chat on the Internet (Signorile, 1997: electronic source). Barebacking has various definitions, but in general refers to intentional anal sex without condoms that may transmit HIV (Mansergh et al., 2002). The Signorile article is

significant because it doubled over panic about barebacking with panic about the Internet and was published in the year following the so-called watershed in the treatment of HIV. The article featured an online chat with a gay man about barebacking and HIV risk in the situation of effective treatment. It is something of a watershed itself in thought about post-crisis risk as it brings together debate over the choice to bareback and the post-crisis situation of treatable HIV. This excitement about unruly conduct is a keynote of a post-crisis understanding of risk. It is a discourse that focuses on the paradoxical notion of reducing threat of death and increasing HIV transmission. And through policy and research, it is also a discourse that fixes on the notional gay man with HIV. Arguably, the idea of the unruly gay man with HIV is the main way of opening to governance the post-crisis paradox of subsiding and increasing risk.

Why research post-crisis?

There are several justifications for researching this paradoxical discourse on treating and preventing HIV in the post-crisis epoch and the way it mobilises an interest in the sexual conduct of gay men with HIV. One of these pertains to some critical perspectives on post-crisis risk discourse anchored in my own experience as a practitioner-researcher. It is also the case that we lack research about how gay men with HIV themselves construct the post-crisis experience of treatment and its implications for their sexual practice. In addition, there is virtue in thinking critically about post-crisis in light of the theoretical perspectives of risk society and risk governance.

A practitioner-researcher critique

My interest in the post-crisis situation has a critical edge, in part informed by my own experience. As someone who had worked in HIV education and research before and after the advent of effective HIV treatment, I had several concerns about thinking and

acting in post-crisis. I had been aware of how previous treatment options had been difficult to take and had been ultimately disappointing. For example, AZT, a kind of anti-HIV treatment trialled in the late 1980s, was found to be not effective on its own (Treichler, 1999). In addition, my experience of HIV education had been in community-based campaigns and services arising in a period when medicine had little to offer. I was therefore curious to know how medical and grassroots responses to the HIV epidemic would work together in light of the advent of effective treatment. But mostly, I was struck with how quickly researchers began investigating the possible impact of treatment on sexual risk behaviour. As early as 1997, twelve months after the previously mentioned Vancouver watershed, researchers had published data that tried to establish a link between hopeful expectations about treatment and flagging safer sex behaviour (Dilley et al., 1997). As I have also noted, using rationalistic models of risk behaviour operationalised in quantitative surveys, this focus on treatment and sex developed into treatment optimism research (International-Collaboration-on-HIV-Optimism, 2003). Research such as this seemed to be a case of the ‘tail wagging the dog’ in the sense that a theoretical assumption was tested apparently without considering lived experience. It seemed to me that treatment optimism research reflected the epistemological interests, perspectives and habits of researchers rather than gay men themselves. This appeared to be particularly the case for gay men living with HIV, who had apparently not been consulted about this imbrication of life expectations and sexual practice in the notion of treatment optimism.

Knowledge gaps

Partly because of how it has been generated, there are significant gaps and flaws in research knowledge about the post-crisis situation for gay men with HIV. There is a large literature about coping and self-care that precedes the advent of treatable HIV

(Bloom, 1997; Crossley, 1997; Thompson et al., 1996). But since the mid 1990s, only a few research projects have attempted a dialogue with gay men to describe and explore in detail how they construct their experiences with treatment, risk and sexual practice (Miller et al., 2000; Rosengarten et al., 2001). Between 2001 and 2003 the Innovative Health Technologies Programme of the ESRC funded a qualitative study about HIV treatment, but the focus here was not sexual practice (Rosengarten et al., 2004). This relative lack of attention to the lived experience of post-crisis may reflect the short time since the advent of treatable HIV. But the lack of research may also reflect the quantitative, rationalistic orientation to HIV prevention research in the post-crisis period. It seems that narrative research has become less important as medicine has settled down to the everyday business of improving treatment and regulating sexual practice. The lack of ability to account for lived experience is a serious problem however as there is no way of countering or questioning the dominant quantitative perspectives on the connections between treatment and sexual practice. For example, we know little about how gay men with HIV interpret the risk implications of HIV treatment and how these intersect with sexual practice. There is therefore a need to provide an account of sexual practice in post-crisis that is situated in accounts of lived experience.

The contribution of theory

The post-crisis situation for gay men with HIV also raises some theoretical questions to do with uncertainty, the regulation of sexual practice and knowledge contests. In particular, aspects of HIV treatment have resonance with the risk society notion of "... manufactured uncertainty" (Beck, 1998: 12). This is the idea that technical and scientific efforts to manage risk have their own risk effects and that because of the propositional character of scientific knowledge, risk management is open to uncertainty

and is contestable. The idea that drug-resistant forms of HIV can be sexually transmitted is an example of manufactured uncertainty. In addition, HIV treatment is to some extent experimental and is linked with different kinds of risks apart from those that pertain to sexual practice. HIV treatment can reduce the risk of illness and death but it can also create the risk of serious and life threatening side effects (NAM, 2003c). Treatment also involves a range of monitoring technologies like viral load and genotype testing (NAM, 2002a; NAM, 2002b). These technologies create knowledge about amount and type of HIV in the body related to the effects of treatment, with implications for health and the sexual transmission of HIV. For example, low viral load test results raise questions about whether treatment also reduces the chance of HIV transmission in sex.

The focus on the risky sexual practice of gay men with HIV also suggests risk governance. In this regard, two theoretical perspectives seem relevant. Giddens's concept of reflexive modernisation provides a way of conceptualising the individual and the social implications of the uncertain qualities of HIV treatment (1998). Foucault's notion of the self-governance of the "... fragile threatened body" is also relevant to the sharpening focus on the risky sexual practice of gay men with HIV (Foucault, 1990: 57). Giddens has asserted that our society "... lives after nature" and tradition, implying that the individual is required to construct a self-made biography with reference to abstract systems such as medicine (1998: 26). In this situation ontological security relies on trust in abstract systems, opening up subjectivity to the travails of knowledge-making in late modernity. Reflexive biography, and the post-structural critiques it has sponsored (Adkins, 2002; Lash, 1993), therefore enables a way of thinking about how people with HIV construct identities in relation to manufactured uncertainty and regulatory discourse circulating in the post-crisis situation. Post-crisis discourse about risk and the conduct of gay men with HIV can also be explored through

governmentality or: "... contact between the technologies of domination and those of the self" (Foucault, 1988: 19). This disciplinary perspective gives rise to the idea that treating and preventing HIV are technologies of the self, or strategies:

... which permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct and way of being so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection or immortality (Foucault, 1988: 18).

In this governmental view, living in post-crisis becomes a matter of self-subjection to the requirements implied by the uncertainties and risk implications of HIV treatment and its connections with sexual and HIV prevention practice. And self-subjection also opens to view the idea of power, drawing attention to the post-crisis assumptions and rules that govern the construction of self.

The research project

This project therefore aims to establish a way of thinking about the links between treatment, sexual practice and HIV prevention that exceeds the current and (apparently) preferred post-crisis mixture of risk rationalism and medical determinism. It is designed to address the identified gaps and flaws in post-crisis knowledge related to the methodological orientation of existing research and some theoretical perspectives related to risk governance. In particular, this project uses an iterative, qualitative interview methodology to illuminate the language, meanings and narrative forms salient to the personal experience accounts of gay men with HIV. By generating accounts of lived experience, the research aims to provide alternative perspectives on living in the post-crisis situation, and in particular, explore how gay men with HIV navigate the

manufactured uncertainties of HIV treatment and the associated questions for identity and sexual conduct. The research also considers how risk knowledge associated with treatment articulates with HIV prevention. It uses qualitative interviews to reflect, in a critical way, on knowledge-making practices in the area of HIV, with reference to assumptions about human action, particularly in the mingling of sexual matters and the capacities and effects of HIV treatment.

Between 1999 and 2000, I interviewed and re-interviewed gay men with HIV about treating and preventing HIV in post-crisis. First, I interviewed 25 gay men attending a HIV treatment clinic in London, as part of an epidemiological study about treatment and sexual risk behaviour funded by the Medical Research Council (Stephenson et al., 2003). I spoke with these interviewees about their HIV diagnosis and treatment experiences, the interpretation of the information derived from viral monitoring technologies, and sexual practice with reference to circulating knowledge and HIV prevention messages. These interviews have been analysed and reported in the literature (Davis et al., 2002). Building on this analysis, in 2000 I re-interviewed eleven of the volunteers. The first interviews suggested that the idea of treatment optimism in sexual practice was not so relevant to the interviewees, mandating further discussion about the connections between treatment and prevention. In addition, the first interviews had indicated that volunteers wanted to explore treatment-related uncertainty and implications for personal security. And I wanted to make connections between the empirical work and the frameworks of risk reflexivity and governmentality. The re-interviews therefore addressed uncertainty and self-governance in connection with life expectations and sexual relations.

Overview

Chapters two and three expand on the theme of post-crisis using the perspectives of risk society and governmentality. Chapter two defines some key concepts for this thesis. It also outlines and critiques the main research approaches that have been applied to or that shed light on the post-crisis experience of gay men with HIV, including the idea of risk reflexivity and HIV treatment. Chapter three develops this notion of risk reflexivity in connection with the social circumstances of gay men with HIV and makes the point that post-crisis concerns over treatment and sex are part of a general contest about how treatment is to be used to manage the epidemic. This larger question about medical technology is traced into HIV treatment advocacy politics and the idea of 'reflexive treatment'. Chapter four clarifies the research focus and describes and justifies the qualitative interview methodology used in this thesis. Chapters five, six and seven concern the thematic analysis of the interviews and re-interviews. Chapter five develops an argument about the multiple and contradictory meanings of post-crisis for gay men with HIV and some implications for HIV prevention. Chapter six considers risk reflexivity in connection with the disciplinary qualities of treatment and prevention, with reference to how these overlap in sexual practice. By drawing on the conceptual framework established in chapters five and six, chapter seven engages with HIV prevention in connection with the concept of variable virus revealed in blood testing for treatment. This chapter therefore explores the uncertain and contestable qualities of risk knowledge and its implications for sexual practice. In chapter eight, I conclude the thesis by suggesting a way of understanding the post-crisis experience that both addresses a lack of knowledge and problematises current orthodoxy. I also consider what this thesis suggests about how to conceptualise treating and preventing HIV in the post-crisis situation.

CHAPTER TWO: RESEARCHING THE POST-CRISIS HIV EPIDEMIC

Introduction

This chapter establishes the conceptual domain for this thesis in further detail. It develops the critical perspectives on how the post-crisis experience is constructed, with particular reference to the paradox of reducing and increasing risks and implications for the regulation of the sexual practice of gay men with HIV. The chapter also elaborates on the gaps in research knowledge noted in the previous chapter, bringing these into connection with some of the theoretical perspectives of risk governance. The first part of the chapter introduces the reader to some terms, concepts and debates concerning HIV prevention and treatment in the post-crisis situation. In this section, I will also suggest how post-crisis and particularly the mingling of prevention and treatment rationalities can be viewed as a case study of risk society. And I make reference to some specific risk implications that arise through the action of treatment in varying the amount and type of HIV in the body. In the second part of the chapter, I identify the three main research orientations that have been, or can be used to address the links between risk, treatment and sexual practice. These are treatment optimism research articulated through behavioural epidemiology, narrative engagements with post-crisis, and perspectives on risk reflexivity and HIV treatment ‘technology’. I summarise the main assumptions and achievements of each of these research orientations. I also develop a critique of each orientation and suggest how research about HIV treatment and the sexual practice of gay men with HIV could be developed through the idea of ‘reflexive treatment’.

Key post-crisis concepts

In this section, I help orient the reader to the complexities of the post-crisis situation. I will argue that the post-crisis situation sponsors a re-working of the relationship

between HIV treatment and prevention figured around the paradox of reducing and increasing risk. Post-crisis has also been addressed in different ways in medicine and by social researchers, suggesting divergent meanings. It also seems that treating and preventing HIV are joined in the sense that they each have a connection with hoping to prevail over threat to life. I also establish how the post-crisis situation for the sexual practice of gay men with HIV can be understood using some of the theoretical perspectives that arise in the writing of Beck and Giddens. I will therefore map out several perspectives on HIV treatment that arise in the theoretical work about reflexivity and risk society: manufactured uncertainties connected with the properties and uses of treatment, the contestable qualities of knowledge about risks associated with treatment effects, and the implications of the growing capacity to manipulate HIV.

The two faces of HIV treatment

The idea that the advent of effective treatment comprises a definite medical watershed is connected in several ways with the paradoxical quality of risk. The idea that treatment has reduced the seriousness of AIDS is thought to be the basis for increased risk of HIV transmission. There is a pronounced policy shift towards describing the HIV epidemic in terms of normalisation and chronic, manageable disease, implying a subsiding sense of crisis about risk of death and serious illness. But because of these effects on the bodies and minds of people with HIV, there is concern over growing problems for preventing HIV. In a sense, HIV treatment has helped to overcome the AIDS crisis, but is implicated in the production of a 'post-treatment' HIV prevention crisis. Policy and research has therefore come to focus on finding ways of combining treatment and prevention to maintain control of the epidemic.

The idea of a changed epidemic with new challenges for HIV prevention is commonly

referred to the mid 1990s when effective treatment became widely available. As discussed in chapter one, the 1996 International AIDS Conference in Vancouver presented scientific papers confirming that effective HIV treatment could be achieved through the combination of drugs called Protease Inhibitors with other drugs that had proven less useful (Holzemer, 1997; NAM, 2003a). There is now general recognition that medicine has reduced death but that HIV prevention faces new challenges. One area of concern is the potential for resurgence of HIV transmission. Based on epidemiological rationales, concern about HIV transmission has several aspects. There is speculation that HIV transmission will increase because of growth in numbers of people living longer with HIV and therefore a simple arithmetic^{al} increase in the chance of risky sexual practice. A variation on this idea is that better health will lead to increased sexual activity among people with HIV, leading to increased risk of HIV transmission. It has also been suggested that if people undergoing HIV treatment fail to take it properly, drug-resistant mutations of HIV will arise. These drug-resistant forms of HIV can then be transmitted to other HIV positive and HIV negative people, compromising the effectiveness of treatment for the individual and in the population. These concerns have made people with HIV, particularly gay men, the focus of research and intervention about risky behaviour, both in terms of sexual behaviour and the effective use of treatment. The focus of prevention in this situation is on the containment of HIV transmission from the seemingly growing numbers of healthy, sexually active, and it seems, unruly, gay men with HIV. These concerns about the connections between treatment and prevention give an impression of the dissolving of AIDS as a health crisis, but a paradoxical multiplication of concerns and interests in the regulation of HIV transmission risk.

Researchers and policy-makers have argued that a key strategy for this post-crisis

situation is to be found in increased attention to the combination of treatment and prevention (Health First, 1998; Kelly & Kalichman, 2002; Laporte & Aggleton, 1998; Laurence, 2002). Key concepts in this regard are the notions of the normalisation of the HIV epidemic and that it has become one of many chronic illnesses that beset modern societies. Both these concepts imply that the material and symbolic presence of HIV and AIDS has changed because of treatment. Normalisation refers to the idea that through time and effective treatment, HIV has become non-exceptional and integrated into systems of health care delivery. This is a perspective that is close to a form of medical determinism, where effective treatment makes HIV a more 'normal' (less crisis) public health issue. It would appear that normalising policies about HIV have gathered strength since the advent of effective treatment. Some have made calls to abandon the term AIDS based on the premise that the term no longer represents anything of clinical significance, giving rise to a notion that treatment has made HIV into an ongoing, chronic condition (Greene & Ward, 2002; Siegel & Lekas, 2002). Others have suggested that AIDS is 'disappearing' from view, a process that has consequences for how HIV risk is understood by those at risk of infection (Bochow, 2002). Treatment is also said to produce a duality in lived experience, where: "... normalisation mainly means a longer life, but - and this is the price of the disease becoming a chronic one - not a healthy life throughout or one free from professional intervention" (Rosenbrock et al., 2000: 1617). Medical practitioners themselves have noted how effective treatment can produce a kind of medicalisation that blames the patient who does not do well with combination treatment (Selwyn, 1998). These analysts seem to recognise that normalisation brings about a set of negative effects for the patient and for society.

Attention to the connections between treatment and prevention also reflects knowledge that treatment has prevention properties of its own. However, the development of

biomedical forms of prevention also mobilises a focus on the risk practice of people with HIV infection. For example, medicine provides an institutional context for risk management and it is a situation for the production of research and intervention about risk (Department of Health, 2001b). In the UK, outpatient HIV treatment is frequently conducted in sexual health clinics. Physicians providing HIV care also work as sexual health specialists. People with HIV use clinics on a regular basis to monitor HIV and gain access to treatment. A recent White Paper about HIV and sexual health policy for the UK made an argument that HIV treatment and sexual health need to be situated together in the same institutional settings to be able to address risk practice among people with HIV infection (Department of Health, 2001b). An editorial in the leading journal *AIDS* concerning HIV prevention with people with HIV, advocated for clinic-based behavioural interventions (Crepaz & Marks, 2002). Also, since 1996, community-based service providers such as Body Positive and the London Lighthouse have closed or altered their services in recognition of the improving health of people with HIV (Cairns, 2000). It can be argued then that one post-crisis ‘effect’ is that the clinic has been re-centred as a site of articulation between people with HIV and medical forms of risk reduction. Unsurprisingly, the HIV clinic supports various bio- and psycho-medical approaches to risk reduction. Because it reduces viral load, treatment takes on significance as a form of intervention, for example, post exposure prophylaxis for occupational or sexual exposure (PEP) (NAM, 2003b). The psycho-medical strategies based in clinical services include interventions that assist people with HIV to inform their sexual partners to enable them also to be tested for HIV (Fenton et al., 1998). Medical services are also interested in individual and group-based cognitive behaviour modification for reducing risky behaviour (Marks et al., 1999; Shriver et al., 2000). These strategies underline how medical forms of HIV prevention are figured around the ‘application’ of treatments of various kinds, to the bodies, minds and social relations of

people with HIV.

Post-crisis as social change

In contrast with the ‘medicalisation’ of prevention, social researchers have offered an alternative way of thinking about the post-crisis situation and therefore how to address HIV prevention. It seems possible to argue that concerns that effective treatment may undermine prevention is a pre-existing epidemiological assumption and therefore not particular to the post-crisis situation. Unlike public health medicine, social researchers have also conceptualised the post-crisis situation as a dynamic social domain, bound up with, but exceeding the advent of effective treatment.

It is not a new idea that treatment can increase HIV transmission. In 1989, Watney noted that the authors of an editorial in *Nature* had discussed how: “... general use of AZT might increase the potential for spreading infection” (1989: 12). It seems that in the late 1980s, it was possible for some to assert that the treatment of HIV infection might lead to an increase in the epidemic spread of HIV. The idea that AZT might contribute to the spread of HIV resembles more recent, post-crisis constructions of the risk-producing aspects of effective HIV treatment and the need to adopt a containment orientation in prevention (Kalichman et al., 1998). Post-crisis thinking about HIV prevention therefore has origins in a pre-existing approach to the connections between the treatment and prevention of epidemic risk.

Social researchers have also identified some of the social aspects of the post-crisis situation and the changed terrain for HIV prevention. For example, Watney has suggested that: “Most people no longer speak of AIDS as a crisis. It has become part of the general social and mental furniture of our times” (2000: 260). A study of news

media has suggested that since the mid 1990s, HIV is portrayed as a medical problem as opposed to a public health concern and has therefore become less important in media representations of health risks (Lupton, 1998). A study of gay communities living inside and outside the large urban centres most affected by the HIV epidemic gave rise to the term 'post-AIDS' (Dowsett, 1998). These researchers used post-AIDS to denote the different and shifting social contexts of risk subjectivity in relation to the history of HIV and on that basis elaborated on new educational agendas for effective HIV prevention. These analysts have recently defined their meaning of post-AIDS:

By 'post-AIDS' we mean a fragmentation and multiplication of gay community responses to HIV/AIDS, a differentiation in both experiences and consequences that warranted a new, multifaceted approach to health education among gay men, whether HIV-positive or negative (2001: 209).

Dowsett et al also draw a distinction between their notion of post-AIDS and post-crisis: "Post-AIDS describes a more detailed configuration of the lives of gay men and shifts in their disposition toward sex, sociality and community" (2001: 209). Presumably they mean to say that post-AIDS is not literally about the advent of HIV treatment in particular, but about the history and geography of the epidemic in general. For example, these researchers point out that compared with gay men living in urban centres with high HIV prevalence, gay men living outside gay communities have always had a different kind of engagement with HIV risk. In contrast, Rofes has used the idea of 'post-crisis' to characterise the risk concerns of the 1990s compared with those of the 1980s (1999). Rofes refers to the "... emerging cultures" of gay men in the late 1990s and of "... community beyond crisis" (1998: 28). A key theme in his analysis is the contest between an orthodox view of how to manage the HIV epidemic and the day to day practices of gay men living after the "... protease moment" (1998: 46). For example:

These changes challenge much of the rhetoric produced by AIDS activists and service workers, who argue that gay men must not move forward without keeping AIDS as the sole centre of their collective cultures. The everyday lives of gay men throughout the nation demonstrate otherwise, and make clear one thing: AIDS-as-crisis, as defined by epicentre gay men in the 1980s, is over (1998: 28).

Taken together, these perspectives encourage a view of change connected with the HIV epidemic that embraces but exceeds the advent of treatable HIV. They suggest the reorientation of HIV prevention in light of effective HIV treatment and the changed meanings of risk as a matter of the history of sexual communities engaged with a dynamic epidemic. These perspectives also suggest the importance of meaning, identity and social differences in engagements with HIV and therefore provide a counterpoint to medicalised accounts of the post-crisis situation. In particular, these social and gay community perspectives suggest that the post-crisis situation may not be a straightforward, medical watershed in the history of the epidemic.

Hope and the interface of treatment and prevention

It also seems possible to argue that treatment and prevention in the post-crisis situation share a genealogy in hoping to prevail over the threat of HIV. Up until recently there was an assumption that behavioural forms of prevention were central to the control of the HIV epidemic, for example:

Although an effective vaccine or a definitive cure currently evades biomedicine, behaviour change has been demonstrated to be a potentially effective means of slowing the spread of the virus ... (Aggleton et al., 1994).

In a sense, the need to change social practices to prevent HIV infection is a way of addressing the lack of a biomedical solution. At the same time, the lack of a biomedical solution for the HIV epidemic has several implications for the social value of treatment. In general, the insufficiency of biomedicine displaces it as a method for managing the epidemic, but at the same time, hope for a biomedical solution is mobilised (Delvecchio-Good, 2001; Delvecchio-Good et al., 1990). Treatment and prevention are therefore joined in the sense that they both articulate with hope for controlling the epidemic.

Treichler has also drawn attention to hope in the curative properties of HIV treatment and the kinds of social investments that are made in treatment (1999). Treichler provided an account of a 1988 conference about AZT. In discussion about AZT toxicity and treatment effectiveness, one doctor outlined how health care was comprised of three interrelated aspects: medical care; self-care and positive thinking. He was noted as having said: "... if we're offering hope with AZT that strengthens the clinical benefit" (quoted in 1999: 304). This statement reveals how one treatment substance can be held to have importance in different aspects of health care including self-care and 'positive thinking'. Moreover, it seems that toxicity and uncertain effectiveness need to be measured against the hope and self-care that can be inspired in patients. And it seems that hope has been reinvented for the post-crisis situation:

... treatment also enhances prevention socially. By treating people we offer them hope. And by offering hope in this epidemic, we dispel the notion that AIDS spells doom, that confronting it is fraught with failure, and that once infected the subject can face only debilitation and death (Cameron, 2001: 5).

This quotation inflects the articulation of treatment, prevention and hope with new value

for the post-crisis era. It suggests how treatment and prevention can be joined to promote the effective management of the epidemic. But the quotation also contradicts the idea that improvements in treatment might lead to increases in HIV transmission. There is then an unsettled quality to discourse about how to combine treatment and prevention and their respective connections with hope.

Post-crisis as a risk society case study

The post-crisis notion of the connections between treatment and HIV transmission suggests risk society. This resonance with the risk society perspective is most obvious in the action of treatment itself. Broadly speaking, HIV treatment works by interfering with the capacity of the virus to replicate itself in the bodies of infected people, thereby halting its progressive damage of the immune system. Treatment therefore also implies the capacity to manipulate HIV in terms of amount and type. This capacity to manipulate is the source of both problems and benefits for HIV prevention. For these reasons, the advent of treatable HIV reflects the risk society notion of “... manufactured uncertainty” (Beck, 1998: 12).

By way of example, the manufactured uncertainties of HIV treatment are reflected in news headlines from an email bulletin provided by *aidsmap*, an internet based service for people with HIV and health care practitioners (www.aidsmap.com). Here are some examples of headers from a weekly bulletin for a week in April 2003:

1. NEWS

- *****
- **Multiple risk factors found for diabetes in HIV-positive HAART patients
 - **Atazanavir resistance: use as second or third line PI should not be ruled out
 - **HCV protects against abnormal blood lipids in HAART-treated HIV patients

- **Fibrates and statins safe and effective in HIV-positive patients with high lipids
- **Gay men, female condoms & anal sex - myth or reality?
- **Anabolic steroid oxymetholone safe and effective treatment for HIV-related wasting
- **Hepatitis A vaccine safe in people with HIV, but effectiveness linked to CD4 count
- **Coronary heart disease risk highest in HIV patients with fat loss?
- **Regulating saunas makes no difference to overall amount of unprotected anal sex had by gay men
- **Psychologically distressed injecting drug users progress to AIDS quicker
- **Adherence the factor most associated with HIV suppression in semen
- **‘Inspirational’ Nkosi Johnson honoured by London HIV clinic

Each of these story headers (apart from the last one), implies some question of risk related to HIV treatment, such as, health risks for those taking treatment, evidence about treatment decisions, the social and psychological factors that predict illness, and research about how to prevent HIV transmission. The headers suggest how the management of the HIV epidemic in the post-crisis situation relies on debate over the scientific and technical aspects of treatment. In addition the headers reveal another aspect of the paradoxical quality of the post-crisis situation, where treatment is both HIV-risk reducing and health-risk producing. For example, “Adherence the factor most associated with HIV suppression in semen” suggests that treatment can reduce HIV transmission. However: “Coronary heart disease risk highest in HIV patients with fat loss?” suggests the drawbacks of taking treatment. The uncertain and paradoxical qualities of treatment underscore how the control of risk is undertaken: “... in the context of conflicting, changeable scientific and technological information” (Giddens, 1998: 32). It seems that

the area of HIV is thoroughly risk oriented both in terms of elaborating on how to manage it through treatment and related technologies and in terms of the provisional and contestable qualities of such methods.

Treatment side effects are the most obvious aspects of the post-crisis situation that foreground manufactured uncertainty. For example, there are significant uncertainties concerning how to optimise treatment, avoid unwanted treatment side effects and moderate the spread of drug-resistant HIV (NAM, 2003c). Researchers have found that drug resistance arises even with optimum prescription and dosing adherence (Bangsberg et al., 2003). Quantitative and qualitative research with people with HIV has elaborated on how people with HIV adapt to new treatment in daily life (Lee et al., 2002) and has also concerned itself with, what has been called, psychological functioning and coping skills (Clement & Schonnesson, 1998; Reeves et al., 2000). Research has focused on topics such as the impact of side effects on treatment adherence (Duran et al., 2001) or on the psychosocial impact of side effects on well-being (Oette et al., 2002) and body image (Chapman, 1998). Recent research with HIV doctors has discussed the tempering of expectations about treatment in light of the difficulties of side effects and growing drug resistance (Rosengarten et al., 2004).

The intersection of treatment and prevention can also be understood in terms of manufactured uncertainty. In particular, the header: “Adherence the factor most associated with HIV suppression in semen” underlines the idea that the viral suppression effects of treatment have connections with risk of HIV transmission. This notion of viral suppression is the source of a key post-crisis irony. As I have mentioned, a central post-crisis concern is the rise of HIV transmission because of the use of treatment and the related issues of the development and spread of drug-resistant forms of HIV. The post-

crisis situation is therefore open to manufactured uncertainties in relation to putative treatment effects in HIV transmission from people with HIV infection. However, it is the case that anti-retroviral treatment is used to reduce the risk of both occupational HIV transmission (post exposure prophylaxis, PEP) and sexual transmission (post exposure prophylaxis for sexual exposure, PEPSE) (NAM, 2003b). Research suggests that optimal treatment and therefore suppression of HIV in individuals and populations can reduce the risk of HIV transmission (Gottlieb, 1998; King, 1998; NAM, 1998b; Porco et al., 2004; Tachet, 1999; Vernazza, 1997). The notion of treatment increasing HIV risk is therefore joined by its own risk-reducing properties. In connection with HIV transmission then, there is a kind of manufactured uncertainty to do with the co-existing increase and decrease in risk of HIV transmission attached to the effects of treatment itself.

The idea of variable HIV

The capacity of treatment to manipulate HIV has resonance with the notion of risk society, because of its connotations of manufactured uncertainty, but also in terms of dissent about appropriate HIV prevention behaviour. Monitoring the variation of HIV in an individual's body in terms of amount and genotype is a central task of clinical management of HIV treatment. There are several blood tests used in HIV treatment that measure variation in virus type and amount, including viral load and genetic tests. The viral load test estimates the amount of virus in the blood (NAM, 2002b). The index of viral load is used to infer the amount of viral activity in the body. Genetic tests are used to determine the genetic characteristics of HIV in the body, particularly to determine the presence of drug-resistant forms of HIV (Pozniak et al., 2001). These tests have the effect of revealing forms of HIV such as 'undetectable' virus and drug resistant virus types. Variable amount of virus may mean that the chance of transmission of HIV also

varies, leading to questions about how people interpret knowledge derived from clinical markers in relation to their safer sex practices (Kalichman et al., 2002; Kravcik et al., 1998). Several laboratory and clinical case studies have documented instances of reinfection with different genetic types of HIV, including drug-resistant forms (Bernard, 2002). These findings have been taken to support advice that people with HIV should have safer sex with other people with HIV (Bernard, 2002).

The idea of reinfection is a particularly salient example of debate about the HIV prevention implications of HIV treatment. Reinfection implicates the dosing and sexual behaviour of the individual in risks for themselves and for the population. Poor adherence is said to contribute to drug-resistant forms of HIV that can be passed on in sex. This joining of individual and population is another way that HIV medicine and prevention are brought close together in the post-crisis situation. However, the idea of reinfection is contentious. Its scientific basis is open to dispute (Bernard, 2002). Drug-resistant forms of HIV can form even with optimum drug adherence and without risky sex (Bangsberg et al., 2003). Such contention is an echo of the risk society perspective. Reinfection risk is the subject of dissonant explanations: between risk as a technical aspect of treatment and risk as a matter of the conduct of the patient. People with HIV are part of risk society in the sense that they: "... have to have, a much more dialogic or engaged relationship with science and technology than used to be the case" (Giddens, 1998: 32). But along with uncertainty, the debatable implications for treatment management and HIV transmission in sexual practice mean that this dialogic relationship is imbued with contest over how the person with HIV should conduct themselves.

Research about treatment and sexual practice: critique and development

Post-crisis is therefore a situation that touches on risk dualities, hope and fear, new

questions for the relationship between HIV treatment and prevention, and uncertainty and dissent over the risk management potentials of HIV treatment and patient conduct. These considerations have an underlying rationality of promoting the most effective combination of treatment and prevention for the post-crisis situation. This imperative mobilises concern about how well people with HIV use their treatment and avoid risky sexual behaviour. This concern is comprised of questions about the relaxation of commitment to risk avoidance in sexual practice because of treatment itself, its risk-reducing properties, or a more general post-crisis situation of lessening fears about HIV infection. There has been much research on just these subjects, but as I will argue, there are significant problems and gaps. This section provides a conceptual map and critique of the three main orientations to research about the connections between treatment and risky sexual practice. These orientations comprise: treatment optimism research derived from behavioural epidemiology; personal experience narrative about post-crisis; and research that has explored the reflexive application of the risk management potentials of various aspects of HIV treatment. I consider each of these orientations in turn, mapping out their features and contribution to the current topic. And I develop a critique of each orientation with the purpose of suggesting how to develop research about the connections between HIV treatment and sexual practice for gay men with HIV.

Treatment optimism and risky sex

Treatment optimism-style research relies on two ideas: that expectations of effective HIV treatment, and therefore reduced fear of either HIV infection or its health consequences, have led to increased risk behaviour; and that through the idea of risk compensation, people who use treatment may take more risks in sex than those who remain untreated. This orientation features a mixture of psychological and individualised explanations of agency and a kind of nativism about risk behaviour in the presence of

treatment. Treatment optimism research is also the dominant orientation to treatment and risk behaviour in the post-crisis situation. It is a prolific orientation in terms of research product (Crepaz & Marks, 2002; Kalichman, 2000; Summerside & Davis, 2002). And it is hegemonic in terms of defining how to understand risk behaviour in the post-crisis situation. Because of reports of increases in risky behaviour among gay men in surveillance studies done since 1996, the treatment optimism thesis has taken on a central importance to risk behaviour research (International-Collaboration-on-HIV-Optimism, 2003).

The treatment expectations thesis has two main ways of explaining the connection between treatment and risk: perceptions of infectiousness; and improved life expectations. Psychological theory postulates that perceptions of the risk of sexual behaviour are linked with knowledge of how treatment reduces HIV viral load and therefore infectiousness. Perceptions that sexual practice is less likely to lead to HIV transmission are thought to lead people to be 'relaxed' about condoms or dispense with them altogether. Also, information about viral load may lead people to believe that specific events of sexual intercourse carry less risk for HIV transmission, an expectation that may be particularly relevant for people with HIV who are aware of the sorts of effects treatment has on viral load. The other sort of treatment expectation concerns the seriousness of HIV infection. It is theorised that improved life expectations and reduction in the threat of death has led to a reduction in fear and therefore reduced motivation to do safer sex. Effective treatment may also lead to a situation where AIDS is portrayed as a chronic manageable disease, perhaps also reducing the perceived risk of AIDS and encouraging complacency.

The notion of treatment expectations is also a quantitative construct that is the focus of

some debate among researchers. It is derived from measures of agreement with statements such as: “New medical treatments for HIV/AIDS make safer sex less important than it was”; “AIDS is now very nearly cured”; “Safer sex is as important now as ever” (Kelly et al., 1998: F93). There is some empirical support for an association between treatment expectations and risky sexual behaviour among gay men in general (International-Collaboration-on-HIV-Optimism, 2003). But these findings are not conclusive. An Australian repeated cross-sectional study has shown that ‘optimism’ about treatment reduced over the period 1997 to 1999 (Knox et al., 2001). In London, researchers used a repeated cross-sectional method to investigate treatment expectations over time among gay men (Elford et al., 2002). They found that while unsafe sex was associated with treatment expectations, the relationship remained constant over time, suggesting other factors (and not just treatment expectations) were contributing to the *escalation* of risky sex in the post-crisis situation. However, other researchers continue to argue that aspects of treatment expectations are related to increased risk behaviour (Dilley et al., 2003; Stolte et al., 2004).

In the risk compensation approach, researchers have compared the frequency of the risky sexual behaviour of those on and not on treatment or measured the relationship between risky sexual behaviour and clinical markers such as viral load (Kravcik et al., 1998; Remien et al., 1998). This approach combines the idea of treatment as a native property of the subject and the risk compensation notion derived from research about the introduction of seat-belts and car accidents in the UK (Adams, 1995). The seat-belt research found that car accident injuries did not decline with the introduction of seat-belt legislation, presumably because people drove more recklessly with the knowledge that they were ‘safer’ in their cars. One study compared the risky sexual practices of gay men on and not on HIV treatment (Stephenson et al., 2003). However, gay men taking HIV

treatment were no more likely to have unsafe sex, suggesting that treatment itself was not important for risk behaviour and therefore questioning the relevance of the risk compensation thesis.

These ambiguous findings about treatment and risk behaviour lead us into a quandary, another echo of the notion of manufactured uncertainty. Risky behaviour seems to be associated with treatment optimism, but not in a way that explains escalating risk behaviour since the advent of treatable HIV. One possible explanation for this problem of explanation might be how treatment optimism-style research has conceptualised social action, in particular, reflexivity concerning risk knowledge connected with treatment. Theorising about how treatment might influence risk behaviour relies on some of the frameworks elaborated in health psychology. The key psychological approach to risky health behaviour is the Health Belief Model (HBM), which has carriage in the area of HIV (Bloor, 1995; Rhodes, 1995). HBM-style research and intervention pivots on the notion of a rational actor who is capable of, and interested in, weighing up risks and acts according to those judgements. There is an argument however, that HBM over-constructs the individual. Researchers have suggested that the extant HBM models of HIV risk behaviour are limited because they fail to address the relational aspects of sexual interaction (van Campenhoudt, 1999). The HBM itself has its origins in attempts to explain why, in the mid 20th century, some individuals did not take up polio vaccination (Armstrong, 1993). It can be suggested then that the HBM, or the focus on health individualism more generally, is an attempt to explain unruliness, or perhaps even a grand exercise in compliance, a perspective that resonates with post-crisis interests in the drug-dosing and sexual practices of people with HIV. It is also important to note how, via health technologies such as vaccination or HIV treatment, we discover, eventually, the disciplinary aspects of public health medicine.

The risk compensation model can also be critiqued. For example, by making an analogy with Adams's model of seat-belt risk compensation, researchers suggested that condom promotion itself leads gay men to have more sex that might transmit HIV (Richens et al., 2000). This assertion is justified by several assumptions. People who want to avoid HIV infection are more likely to use condoms, so in effect condom promotion reinforces behaviour with an element of risk. Because condoms fail on occasion, an arithmetic increase in use will also increase condom 'accidents', presumably undercutting the protective virtues of condom use. Condom use may also mean that gay men do not reduce their number of sexual partners, or may even increase their number of sexual partners, in the false belief that they are protected from HIV transmission. Following Adams's argument, these researchers assert that condom promotion may do little to curb HIV transmission. However, the nativist rationality of risk compensation underplays other aspects of condom use such as sexual culture and social relating. The conceptualisation of risk compensation in the area of HIV is also overwhelmingly HIV-negative centric. It relies on a notion of how individuals act in terms of being at risk of HIV infection and therefore has less to say about the situation of people with HIV. And applied in the area of HIV risk, it also appears to have the unfortunate effect of deconstructing risk intervention in general.

It also appears that HBM and risk compensation research make different assumptions about social action and intervention. The individualism of HBM research leads to a slippage where the presence of risky behaviour becomes a signifier of identity. This slippage occurs because the research associates risky behaviour with conceptions of individual volition and psychological processes, so that the person becomes a focus for intervention, as opposed to social practices. Conversely, the risk compensation model

underplays reflexivity. For example, such studies most commonly do not also operationalise perceptions connected with treatment. In this way, the psychological and social aspects of the treatment experience are set aside. Both models are therefore somewhat limited in terms of their capacity to explain the connections between HIV treatment and risky sex. Moreover, the ambivalent empirical findings that these models have sponsored, suggest their conceptual limitations.

In addition, the HBM and native risk models share a common interest in surveillance, as opposed to explanation. Castel has made an argument that health risks are managed as a matter of "... systematic predetection" (Castel, 1991: 289). Risk measurement science is less interested in the risky behaviour of individuals, and more interested in the distribution of risk factors in a population. In this measurement of risk, the individual subject disappears:

There is no longer, in fact, a relation of immediacy with a subject, because there is no longer a subject. What the new preventive policies primarily address is no longer individuals but factors, statistical correlations of heterogeneous elements (Castel, 1991: 289).

As the individual disappears, so does the social and historical location of their practice and relationships. It can be argued then that HBM or native risk models of the connections between sex and treatment do not refer to lived experience. And the transmission of knowledge about risk is organised around an idea of an individual(s) 'reconstituted' through statistical risk factors. There is then scope for a separation between lived experience and the risk knowledge of the scientific methods of systematic predetection. It seems possible to argue that the area of research about the connections between treatment and risky sex suffers empirical ambivalence and conceptual

limitations. Moreover the area is open to inquiry that does focus on lived experience, situated accounts and the meanings and practices of reflexive actors.

There is also a cultural critique of the individualism and nativism of risk behaviour research. Douglas has developed a critique of the use of psychology and epidemiology to theorise about risk practices in general (Douglas, 1992). This critique argues that the individualising and decontextualising effects of risk measurement obscure the social and cultural aspects of risk. A major theme in Douglas's account of risk is that people manage risk as a matter of preference informed by how one understands one's membership of a social group (Douglas, 1992). In this way risky practice may be chosen because of its social value. This kind of choice is not 'irrational' as such and therefore provides a challenge for the kinds of explanations of risk behaviour that arise in models of risk individualism. Douglas and Calvez have also used an adaptation of a cultural model of risk and 'citizenship' to explore identity and risk practice in connection with HIV, giving rise to a holistic explanation of risk management (Douglas & Calvez, 1990). Lupton has taken these cultural notions of risk into research about how risk-taking can be attractive for people (2002a; 2002b). Partly based on qualitative interview research about HIV prevention with people with HIV, Rhodes has developed the idea of 'situated risk management' (1995). This framework emphasises the interpersonal and cultural situation of risk management practices. It addresses reflexivity and the meanings of risk circulating in social situations.

Narrative engagements with post-crisis

Narrativity is another important orientation to research about the post-crisis situation. Narrative research has not ostensibly addressed treatment and sexual practice. But such research raises a valuable counterpoint to the treatment optimism orientation with its

focus on psychological and nativist explanations of risk behaviour. Narrative also foregrounds personal experience, different senses of being-in-the-world with effective HIV treatment, challenges to personal security and the constructedness of post-crisis. Narrative research also reveals that much of the extant research about the HIV experience has relied on certain assumptions about the HIV story and the advent of treatment, including, a linear form to HIV illness narrative and an equally linear sense of HIV treatment progress and its effects in sexual practice. Narrative therefore affords a critique of some post-crisis assumptions, such as the notion of medically-determined watershed and rationalistic action. Narrative suggests a view of the HIV epidemic as a dynamic intertwining of prevention and treatment where speaking positions and identities are at stake.

Illness narrative has been one of the paradigmatic theoretical perspectives for researching the 'impact' of HIV in the life course (Pierret, 2000). Illness narrative is a prominent research form in the area of chronic illness in general (Bury, 1997; Bury, 2001; Good, 1996: 144). HIV illness narrative provides a way of thinking through medical determinism or how changes in medicine have influenced expectations, experiences and approaches to risk. Several qualitative studies were conducted in the early 1990s about living long term with HIV, often as part of epidemiological studies designed to identify the biological characteristics of people who remained relatively healthy with HIV infection, with a view to identifying possible bases for the development of treatment. Living with HIV has been likened to the situation of diagnosis of illness via genetic technology (Crossley, 1998). This was because the person with HIV faced an uncertain "... temporal horizon" because people did not know whether and when they would get life-threatening diseases and therefore how long they would live (Crossley, 1998: 508). Bloom described gay men with HIV as losing their

‘history’ as they lost the social connections that made up their lives (Bloom, 1997). Roth characterised AIDS-related losses as threats to “... ontological health”, in the sense that the basis of social existence and identity was undermined (Roth & Nelson, 1997: 161). This notion of ‘ontological health’ informed by uncertainty and loss, is a point of connection with ideas about the individual in risk society and “... ontological security” (Giddens, 1990: 92). Specifically, ontological health resonates with ideas about how the individual has to engage with the perturbations of trust and challenges to the “... continuity of their self identity and in the constancy of the surrounding social and material environments of action” (Giddens, 1990: 92).

Moreover, Macintyre has suggested that questions over ontological security for people with HIV are linked with the epistemological traditions of medicine itself (1999). In the early years of the epidemic, life expectancy was not clear and was constantly reassessed as mortality statistics accumulated. At first, lifespan was thought to be quite short. But over time, lifespan was reassessed and to some extent extended, producing a conundrum. People who had lived beyond the estimated lifespan of someone with AIDS were hopeful of continued survival. But when life expectancy calculations with AIDS telescoped beyond previous estimates, people found that their status and hope as long-term survivors was undermined by an emerging ‘objective’ medical definition of chance of survival. In this way, calculation was entwined with temporal horizon, creating close connections between biomedical epistemology, life expectations, uncertainty and ‘ontological security’. In this observation, Macintyre’s research suggests risk society. People with HIV are in the specific position of the reflexive management of their own survival in the conditions of ambivalent temporal horizon associated with uncertainty and calculability. Macintyre’s research is also important as it locates questions of

ontological security and medical epistemology in the period that preceded the 'post-crisis' era.

With the introduction of effective combination treatment in the mid 1990s, researchers have explored the revival of life prospects and the reconfiguration of uncertainty. In this respect, there appears to be some contradiction about the importance of uncertainty or security to the illness experience. Qualitative research has elaborated on the general themes of uncertainty, hope and quality of life, often with an orientation to helping people with HIV cope with these experiences (Kylma et al., 2001). Brashers conducted focus groups to differentiate the uncertainty thesis into the categories of: hope and future orientation; social roles and identities; interpersonal relations; and quality of life (Brashers et al., 1999). These contexts were framed by a concern about the "... interconnected social and psychological concerns that combine uncertainty about illness and systems of care" (Brashers et al., 1999: 214). In this orientation, the research focused on sensitising health-care practitioners to the problems faced by people with HIV as they adapted to the new treatment situation. The focus of this research was interventionist, for example: "... this study supports Mishel's (1990) contention that individuals with chronic illnesses or illnesses that have a threat of recurrence must be taught to cope with chronic or continual uncertainty" (Brashers et al., 1999: 214). This research also made some surprising recommendations: "... these individuals need to know that life on the new drug cocktails is not the same as life as an uninfected individual" (Brashers et al., 1999: 215). This seems a strange use of qualitative methodology in that it treats the interviewees as unknowing and assumes they need to be tutored into living with HIV treatment. This interpretive practice creates outsiders and insiders, or an expert, observing position. Such research practices hint at a kind of

disciplinarity figured around a normativity of healthiness and an unreflexive engagement with the idea of post-crisis.

Also addressing the advent of treatable HIV, Pierret interviewed a group of long-term survivors in 1996 and 1997 and compared these accounts with those of another group interviewed in the early 1990s (Pierret, 2001). Pierret therefore attempted to address life expectations pre and post the advent of effective treatment. The group from the early 1990s constructed their narratives in ways that helped them to cope with the uncertainty of the life course. The long-time survivor group interviewed in 96/97 constructed uncertainty as an aspect of the past. This difference was taken to signify a change in personal engagements with the question of ontological security for people with HIV infection. Pierret attributed these substantive differences to "... confidence in their stable state of health" among the long-term survivors and possibly also to the advent of treatment in 1996 (Pierret, 2001: 177).

Post-crisis narrative research has also addressed the notion of 'turnaround' in life expectations connected with treatment. The idea of turnaround or the 'Lazarus experience' as it sometimes called, is a significant way of accounting for the effects of treatment because it serves to instantiate post-crisis in a personal way. Turnaround also has the effect of reinforcing the sense of post-crisis as a medically-constituted watershed in the life course. In 1997/98 Trainor and Ezer conducted a study of people who thought they were going to die, to explore the treatment-related turnaround in life expectations arising out of effective treatment (Trainor & Ezer, 2000). Unlike Pierret, Trainor and Ezer found that the removal of the prospect of death created uncertainty for the interviewees. This counter-intuitive aspect of turnaround was understood as arising for interviewees because death had been a given. Rejuvenation of life expectations was

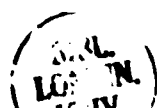
upsetting because it undermined the accepted biography of someone with AIDS. Also using personal accounts, Flowers has discussed this counterintuitive aspect of turnaround in terms of a shift from 'death sentence' to 'life-sentence' with treatment (Flowers et al., 2001). Taken together, these studies suggest that there are several forms of uncertainty. For long-term survivors, the advent of treatable HIV shored up hope. For people who had expected to die, treatment ironically brings about an engagement with uncertainty and new challenges for constructing a sense of being-in-the-world. These perspectives suggest different meanings of post-crisis and in particular, the importance of different methods for constructing personal experience.

Also considering the advent of treatment in lived experience, Ezzy has problematised the idea of a universal shape to stories about life with HIV (Ezzy, 2000). He also critiqued illness narrative theory as helping to constitute modernist assumptions about linear progress and trust in the restorative properties of medical science. Ezzy identified variations on HIV illness narrative, specifically: 'linear restitution narratives', 'linear chaotic narratives' and 'polyphonic narratives'. Ezzy found that "... individual responses to new treatments typically serve to underline, rather than radically change, the type of illness narrative employed" (Ezzy, 2000: 609). Treatment was found to have intensified some aspects of living with HIV as opposed to having created a paradigmatic shift in narrative form. Linearity in its various forms was figured around an assumption of a life course interrupted by HIV and restored by treatment, an orientation that made them inherently "precarious" because of the manufactured uncertainties attached to treatment (Ezzy, 2000: 611). Polyphonic narrative however, embraced multiple meanings and foregrounded some of the paradoxical aspects of hope and uncertainty in the situation of effective treatment. Compared with linear narratives, polyphonic narratives were held to be more "robust" forms of reflexivity about treatment uncertainty in that mutability and

mortality were accepted (Ezzy, 2000: 616). However, and consistent with other researchers, Ezzy reported that the interviewees found new treatment "... frustratingly uncertain" (Ezzy, 2000: 609). Ezzy's research raises questions over the medical epoch conceptualisation of post-crisis.

The perspective that it is possible to construct more than one narrative form for the experience of HIV illness and the advent of effective treatment also resonates with post-structural ideas about sex and sexuality. This resonance is noteworthy because of the post-crisis connection between treatment and sexual practice. Writing prior to the advent of treatable HIV, Plummer used "post-AIDS" to signify how forms of sexual practice take on different meaning in the era of HIV (Plummer, 1995: 136). This seems a more tentative and perhaps ironic use of 'post-AIDS' and is distinct from the meaning used by Dowsett et al in connection with HIV education (2001). Plummer noted how telephone sex takes on meaning as a form of risk reduction in the situation of the HIV epidemic, giving rise to "techno-sex" and the idea of sexual forms that are connected with the reflexive management of the risk of HIV (1995: 136). Plummer has also written about the rise of multiple speaking positions in matters of sexual identity "... as the dominant meta-narrative gets fractured, dispersed or even eliminated" in the late modern era (1995: 142). Similarly, Simon has suggested a shift from paradigmatic to post-paradigmatic in the making of sexual biography:

Paradigmatic contexts are those that realize a high degree of consensual meanings, shared meanings that tend to fit together almost seamlessly, since they are often experienced as being derived from a smaller number of master paradigms that, in turn, are all authorized by some universally shared, ultimate source of truth post-paradigmatic contexts are those where seamless integration of consensual meanings begins to dissolve. Appearing in pluralized



forms, with their underlying assumptions stripped of their unquestionable authority, even the most familiar aspects of social life become sites for conflicting or alternative options (Simon, 1996: 9).

These perspectives serve to underline how the post-crisis story is challenged by the existence of post-crisis *stories* and the different ways that narrators engage with the advent of treatable HIV. The prospect of narrative multiplicity also has a double significance for post-crisis, given the mingling of both life expectations and sexual relations in risk governance.

Narrative also suggests the reversible qualities of accounting for the post-crisis experience. Illness narrative attempts to depict or describe what is, to provide a sense of ontological groundedness. But Foucault offered an alternative in the notion of the “... narrative of illness” (Foucault, 1990: 57). This is a reversal of the sense of narrative as description of lived experience, into a sense that exposes its potential for disciplinarity. This reversal suggests how story-making provides a kind of mode of self-surveillance and therefore has a property of mobilising certain forms of life such as biographical moment or watershed. It is useful to acknowledge these two modes of representation in research about the post-crisis HIV epidemic. The ‘narrative of illness’ and illness narrative together remind us of different constructions of subjectivity and the limitations of the respective determinacies of either discourse or medical technology.

We can therefore see linear narrative forms as cultural products invested in certain assumptions about biography, illness and medicine, and particularly around the relay of the riskiness of HIV and the hopes embedded in biomedical progress. Treichler has pointed out how post-crisis is a discursive construction:

At the same time that “AIDS” is new, however, it is always already occupied, peopled with discourse that predated it and establishing precedent for language not yet invented. The proclamations since 1996 that “AIDS is over” or that “the cure” has been found must likewise be read from this discursive trajectory (Treichler, 1999: 323 and 324).

Treichler noted how a book called *AIDS: the making of a chronic disease* was published in 1992, anticipating a hitherto unrealised treatment context and preceding post-crisis (Treichler, 1999: see page 325). In a sense, the post-crisis story was waiting to be articulated and that in all sorts of ways, biomedical progress and the constitution of certain forms of existence are prefigured in how the HIV epidemic is understood. It seems possible to argue that the epistemological assumptions that underpin narrative linearity have helped to constitute representations of the advent of effective HIV treatment and its ramifications for HIV transmission in sexual practice. This critical perspective also suggests how the production of knowledge about HIV treatment and sexual practice is entwined with certain habits of thought. Narrative therefore affords an epistemological basis for challenging the conceptualisation of the post-crisis situation with reference to the sexual practice of gay men with HIV.

Risk reflexivity and HIV medical technologies

The third research orientation to risk, treatment and sex has the smallest literature. Ironically, it is also the most pertinent for my purposes. I call it the reflexive orientation because it draws attention to how knowledge about different aspects of treatment is applied in daily life by social actors. This reflexive orientation shares some assumptions with treatment optimism research such as rationalistic conduct on the part of individuals and the importance of knowledge for informing practice. But the reflexive orientation

makes some distinctive assumptions about agency and takes care to distinguish the meanings and social value of the different aspects of medical technology used in the area of HIV treatment. And unlike narrative research, the reflexive orientation is eclectic, embracing qualitative and quantitative research and theoretical elaboration. This orientation also favours accounts of reflexivity situated in social relations, culture and history. It draws attention to how people with HIV understand health and future prospects in the lived situations of their sexual partnerships. Research in this perspective suggests that knowledge about the risk management potentials of treatment is incorporated into risk management practice as a matter of reflexive operations in sexual relating. But this same research suggests that, in the post-crisis situation, HIV serostatus identity has taken on a deeper significance as a site for a separation between HIV positive, HIV negative and untested men in relation to how HIV prevention is understood and articulated. I take this to suggest that the post-crisis situation is not properly thought of as only a paradigm shift related to the advent of treatment, but also concerns the superimposition of treatment considerations on HIV serostatus identity. In this situation, the importance of sero-identity does not dissolve, but is renewed and elaborated in relation to the risky aspects of HIV treatment.

Researchers have argued that treatment-related risk reflexivity existed prior to the advent of treatable HIV. Moreover, they also argue that the reflexive use of HIV medical technology has made forms of HIV prevention possible. In the early 1990s, survey findings were interpreted to reveal that gay men used HIV testing and serostatus identity to make decisions about the need for the use of condoms in regular partnerships (Kippax, 1993). HIV negative men in particular were observed to give up condoms with their HIV negative partners. These practices were termed "... negotiated safety" and reflected a reworking of contemporary HIV prevention guidelines of 'use a condom

every time' (Kippax, 1993: 257). These practices were seen to exhibit rational application of risk knowledge connected with the HIV anti-body blood test, itself a form of medical technology. The idea of negotiated safety was an important break in conceptualising HIV prevention, precisely because it foregrounded agency on the part of gay men in HIV prevention practice. Attending to reflexivity in the post-crisis situation. Kippax has asserted that: "... safer sex culture remains intact BECAUSE, not in spite of the incorporation of medicine into prevention" (author's emphasis 1999: 13). Through negotiated safety, medicalisation was present in the lives of gay men prior to the advent of effective treatment. And elaborating on the idea of post-crisis, these researchers have begun to rethink the terms of HIV prevention in light of effective treatment. These researchers have explored the terms of a "conversation" between gay men's sexual culture and public health (Race, 2003: 369). Kippax and Race argue that, in post-crisis, gay men have continued to elaborate on the relevance of medical knowledge for managing risk practice in their sexual relationships (2003). The framework of negotiated safety therefore opens up thinking about risk practice in post-crisis to notions of reflexivity and medical technology for gay men in general. However, it also seems that, for gay men with HIV, some of the specific implications of reflexivity and medical technology remain under-explored.

Also working in a conceptual domain, Flowers has suggested a kind of periodisation of risk reflexivity related to HIV medical technology (2001). He has suggested three 'eras' of reflexive practice: mobilisation; somaticisation; technologisation. The first comprised the early stages of the epidemic characterised by community mobilisation around the notion of safer sex in the context of a lack of scientific understanding of HIV. With the discovery of the HIV pathogen in the early 1980s and therefore the invention of the HIV anti-body blood test, a second period emerged to do with 'somaticisation' and

‘individualisation’. In this period risk management was informed by the idea that some people had HIV and some did not, hence the importance of somatic risk rationality. With the advent of effective treatment, risk management has come to centre on treatment effects and related monitoring technologies (Flowers, 2001). The idea of ‘somaticisation’ draws attention to the presence or absence of HIV in different bodies and therefore the negotiation of risk according to different HIV serostatuses produced by the HIV test. This focus accentuated the importance of individual management of HIV risk reduction connected with self-knowledge of HIV status. However, Flowers has suggested that the advent of effective HIV treatment technologies has disrupted these modes of knowledge and management:

... now this commonality between bodies and HIV status has been eroded by the advent of new testing technologies which address viral activity (viral load, viral resistance) as changing both temporally and spatially, across disease progression and bodily parts (plasma and semen) (2001: 67).

According to Flowers, these new risk divisions lead to a “fracturing” of risk management practices, into increasingly technically differentiated and privatised considerations (2001: 63). This conceptualisation of treatment and prevention has value in that it provides a way of thematising change connected with HIV risk, medicine and subjectivity. But it also subscribes to a kind of medical determinacy that can be questioned in light of narrative engagements with post-crisis.

This notion of reflexivity in connection with HIV serostatus and other aspects of medical technology is not a simply theoretical framework. Empirical research has also suggested that, in particular, gay men with HIV adopt risk reduction strategies according to HIV serostatus (Keogh et al., 1999). For example, qualitative research has suggested

that sex between men with HIV or with men who did not have HIV require different risk assessments and negotiations to do with reinfection and HIV transmission. It has also been suggested that gay men with HIV conduct risk reduction informed by a blend of a rational “balancing” of risk and the customs and practices of sexual interaction (Keogh et al., 1999: 28). HIV ‘re-infection’ was explored in focus groups with gay men with HIV in 1995, prior to the so-called 1996 watershed (Keogh et al., 1995). This research revealed that men made connections between HIV diagnostic tests and infectiousness: “... when my T cells are below 400, then I know that I’m probably very infectious” (Keogh et al., 1995: 32). The researchers discussed this construction as an application of “... medical evidence” to “inform” risk management practices (Keogh et al., 1995: 32). Some researchers have also suggested that some gay men with HIV may select sexual partners who are (or seem to be) also HIV positive to reduce some of the risk management concerns of sexual relating (de Vroome & Sandfort, 1998).

In what has been the major qualitative study on the subject following the risk reflexivity premise, researchers in Australia have explored how HIV medical technologies might have been associated with risk behaviour among gay men (Rosengarten et al., 2001). These researchers argued that sex with and without condoms was not attributed to “... clinical markers” such as measures of viral load (2001: 10). This qualitative perspective therefore underlines the explanatory limitations of the notion of treatment optimism and risky sexual behaviour. However, these researchers also argued that gay men with HIV employed “... individually tailored risk minimisation strategies” and that “... undetectable or low viral load may provide for a reduced sense of infectivity” (2001: 4). According to these researchers, individual risk minimisation included several practices. Gay men with HIV applied knowledge about infectiousness and viral load test results to sexual practice. They deployed epidemiological perspectives such as the relative HIV

transmission risk of insertive and receptive sexual practices. Both disclosure of HIV serostatus or assumptions about it were used to determine the serostatus of the sexual partner. In general however, men who were not HIV positive were not engaged with the risk management potentials of treatment. These authors contended that in the post-crisis era it is possible to have "... a different sense of being positive" (2001: 32). The findings were taken to mean that treatment was not leading to the abandonment of safer sex among gay men. However, the social and sexual relations of risk management did seem to be informed by understandings derived from HIV medical technology, but in relation to an alteration in understanding of what it is like to live with HIV and also with regard to a separation in risk assessment practice figured around HIV serostatus. This nuanced perspective on the link between medical technology and HIV prevention has some support in other research. A Canadian study, also focused on gay men's accounts of the risk impacts of HIV treatment, found that the effectiveness of treatment was not linked with risky sexual practice (Miller et al., 2002). Other more salient risk considerations were intimacy and stigma related to living with HIV, a finding that resonates with previous research about the sexual practice of people with HIV (Cusick & Rhodes, 1999; Green & Sobo, 2000). Linguistic analysis of interview narratives has also suggested that interpretations of viral load have more to do with health than HIV transmission risk (Moore et al., 2001).

Developing the idea of risk reflexivity for the post-crisis situation

The idea of negotiated safety is emblematic of the risk reflexivity research orientation in post-crisis. It provides a viable alternative to the treatment optimism orientation, which has various theoretical and empirical limitations. Risk reflexivity provides a way conceptualising gay men as active managers of HIV risk, using and applying knowledge about antibody testing and the risk potentials of treatment. It also provides a basis for

research on how gay men with HIV might approach the post-crisis situation. But the risk reflexivity orientation can be advanced in several ways. It can be brought into connection with critical perspectives on linear accounts of the HIV epidemic provided by narrative research, particularly those informed by post-structuralism. And there is an outstanding need to make a connection between these risk reflexivity perspectives and the post-crisis situation for gay men with HIV, where there is a particular focus on containing HIV transmission via the management of their risky sexual practice and related questions of identity.

The negotiated-safety idea can be advanced in connection with the social meanings of HIV sero-identity. For example, the negotiated safety idea may not be critical enough of the medicalisation of identity and the stigma connected with HIV positive identity. In general, the negotiated safety idea is derived from quantitative research, not personal accounts. It therefore does not engage with the reflexive construction of risk identity and its management. For example, in qualitative research about risk practice, HIV positive people have been found to place emphasis on the control of knowledge and disclosure about HIV serostatus in sexual relations (Cusick & Rhodes, 1999). It has also been revealed that people with HIV adopted risk management stances to further forms of trust and security in sexual partnerships (Green, 1995; Rhodes & Cusick, 2000). People with HIV have developed strategies for judging with whom and when to disclose to sexual partners about their HIV serostatus and to discuss safer sex. This practice of social judgement differs according to sexual setting, such as love partnerships, one-night stands and backrooms or saunas. We know from other research that AIDS and HIV are identities that carry significant negative meaning, leading into problems of social interaction (Alonzo & Reynolds, 1995; Cusick & Rhodes, 1999; Herdt, 2001; Parker & Aggleton, 2003). Addressing both the idea of treatment optimism and drug dosing

adherence, Bartos and Macdonald have discussed how people with HIV and AIDS dealt with the post-crisis situation in much the same way that they dealt with living with HIV (Bartos & McDonald, 2000). These researchers argued that people with HIV were concerned with: "... sustaining senses of identity, community and solidarity" (2000: 305). These researchers also argued that people with HIV were sceptical (as opposed to the more popular 'optimistic') about the effects of treatment on risk of HIV transmission and in the main were committed to their life-saving treatment prescriptions. People with HIV therefore appear to be focused on managing their identities *and* the viral aspects of HIV risk in sexual relations. It seems that for people with HIV infection, the negotiation of safety embraces the management of identity.

It can also be argued that HIV sero-identity is itself relational, a perspective that embraces, but exceeds the notion of reflexivity that underpins the concept of negotiated safety. Writing prior to the post-crisis situation, Lather explored the social aspects of one important form of medical technology, the HIV antibody test (1995). In Lather's terms, the antibody blood test is a method for defining risk between individuals. The blood test assigns a valency of HIV positive or negative to test results and therefore provides individuals with a relational risk identity. Lather made the point that HIV transmission risk does not reside in positive or negative identity, but in the difference between them. Through valency, the blood test helps create 'risk relationships', for example + to -, - to -, + to +, - to untested and so on. In this sense, medical technology is implicated in the construction of risk relationships figured around knowledge of HIV serostatus. This use of medical technology to define risk relations is highly suggestive of the bio-social constitution of risk relations in lived experience. Medical technology situates risk in the sexual relations of gay men; or by reversal, potentially distributes sexual actors according to their HIV status. It is also important to stress that this

installation of the risk relationship may not be an intended effect of HIV medicine. HIV testing is normally articulated as a way for the individual to get access to HIV treatment, and is not ostensibly about constructing relations between sexual actors. The formation of HIV risk relationships in sexual practice may be an unintended, ‘manufactured’ aspect of HIV medicine. Or, at least, the relational implications of HIV testing are not often considered in its application. In this sense, in HIV prevention, the arrangement of risk relations brought about by the HIV blood test has a status of just being, or a regime of truth, rather than a social experience that is produced. In this view, reflexivity about HIV risk and medical technology is not simply a matter of choosing when and with whom to wear a condom. It also concerns the construction of relationships and identities.

Identity is therefore a central critique of both the idea of negotiated safety and its elaboration in post-crisis. There is another, related question of identity to do with the meanings of HIV and AIDS. Negotiated safety and the notions of reflexivity it has sponsored are somewhat individualised and ‘HIV centric’. For example, some have argued for a “fracturing” of identity related to the advent of effective treatment (Flowers, 2001: 63). Others have asserted that gay men with HIV have adopted “... individually tailored risk minimisation strategies” in the post-crisis situation (Rosengarten et al., 2001: 30). But questions remain about just how disassembled and ‘individual’ risk management can be given the importance of identities and the HIV risk relationship to the constitution of risk management. Writing about post-crisis and identity, Watney has argued for distinguishing between the historical construction of both AIDS and HIV identities. He has argued that the so-called ‘post-AIDS’ notion does not effectively engage with the: “... changing perceptions of what it means to be HIV-positive” (2000: 260). In particular, he notes that prior to the identification of the HIV

pathogen (and therefore before negotiated safety was possible), risk identities formed around the diagnostic category of AIDS. This AIDS identity concerned the sense of illness and mortality linked with an unknown cause. Being ill was the sign of AIDS identity. With the discovery of the virus that caused AIDS and an anti-body blood test, different identities arose, figured around serostatus and opened up to being 'at risk' of HIV infection or progression to AIDS. In this view, the HIV antibody test is itself a technical 'watershed'. Through this unfolding and multiplication of identities in relation to medicine, Watney has also asserted that watershed oriented constructions like 'post-AIDS' are misleading. Instead we need to engage with how: "... the epidemic is constantly changing" (2000: 264). His view also suggests that risk reflexivity about medical meanings precede and therefore exceed the identity and relational properties of the HIV anti-body test. Watney's analysis suggests that in the situation of treatable HIV there is a possible reconfiguration or even dissolution of AIDS identity. Watney's perspectives are important because they introduce into theorising about post-crisis, the different senses of AIDS and HIV identities and a kind of dynamic interplay of identity, risk and medicine. Watney's analysis is also positioned as a point of view of people with HIV, foregrounding how discourse about the experience of HIV is constructed via different speaking positions. Positionality reveals how discourse is assembled to give meaning and that the practice of assembling meaning is open to contestation. Watney also reveals that, in general, most of the debate about post-crisis has been conducted without much reference to the lived experience of people with HIV.

Summary

This chapter has achieved two main objectives. It has defined several concepts needed for the reader to appreciate this thesis. And, via description and critique of the major post-crisis research orientations, I have also identified some avenues for the

development of research about treatment, risk and sex. There is a need to address how the post-crisis situation is understood by gay men with HIV, with reference to sexual practice. In particular, research can engage with how gay men with HIV account for the uncertainty and contestable knowledge about risk associated with HIV treatment. I made a case for the inadequacy of the hegemonic research notion of treatment optimism in its own terms, and in connection with narrative research about the post-crisis experience. I also engaged with the small, but pertinent literature about risk reflexivity that foregrounds how agentic subjects use knowledge derived from aspects of HIV treatment technology. I argued that for gay men with HIV in the post-crisis situation, this reflexive research orientation required some development, particularly in connection with identities, some of the critical perspectives on post-crisis that arise in narrative research and the social circumstances of gay men with HIV. In keeping with this line of argument, in the next chapter I develop this conceptual framework concerning risk reflexivity and gay men with HIV through the idea of contest. In particular, I make reference to questions about responsible sexual conduct on the part of gay men with HIV and the wider concern of setting the terms for use of HIV treatment in the management of the epidemic.

CHAPTER THREE: CONTESTING CONDUCT IN POST-CRISIS

Introduction

The previous chapter suggested the value of the notion of risk reflexivity with regard to HIV treatment and sexual practice. But I also suggested that this notion required development, for example, in terms of social relations, identity and a critique of a universal idea of the post-crisis experience. In this chapter, I make this notion of risk reflexivity more relevant to the situation of gay men with HIV, by connecting it with some other aspects of HIV prevention and treatment in the post-crisis situation. In particular, I will discuss what I have called a contest about responsible HIV prevention behaviour. This contest reveals post-crisis as a domain where the terms of the use of the risk potentials of HIV treatment are being worked out in and through responsible sexual practice on the part of those with HIV infection, and in particular, gay men with HIV. I will therefore argue that the post-crisis concern with treatment optimism and sexual risk practice is one part of a social response to contesting the terms of what I call 'reflexive treatment'. The advent of treatable HIV is significant because it inspires a renewed focus on how the risky aspects of treatment will be used, in the sense of HIV transmission but also in the constitution of forms of life. In the first part of this chapter I identify some of the features of this contest about sexual practice and responsible action. In the second part, I address the notion of reflexive treatment and its applications to the present topic.

Sex and the gay man with HIV

In my most recent qualitative interview work about HIV risk and e-dating via the Internet, some men with HIV have spoken about hate emails (Davis et al., 2004). It

seems that some gay men with HIV make it clear in their Internet communication that they prefer anal sex without condoms and that they have HIV. Others find this so outrageous that they send them disparaging or hateful messages. It seems that in daily life there is an 'argument' going on about HIV risk and sexual conduct. This seems to be a conflictual discourse of choice and responsibility that figures in Internet messaging. But this conflictual discourse is also observable in HIV prevention policy and research in respect of the links between treatment and the sexual conduct of gay men with HIV. In this section, I want to consider this contest in terms of required altruism on the part of gay men with HIV and its regulatory corollary in transgressive sexual behaviour, sometimes referred to as barebacking. I will also consider this contest in connection with sexual community and the importance of security in sexual relations.

The imperative of altruism in sexual practice

The articulation of the particular responsibilities of gay men with HIV has become a feature of social research and policy about HIV prevention. Several analysts have written that prevention should build on the "altruism" of HIV positive people (King-Spooner, 1999: 141). Altruism is also an explicit and implicit assumption in much research concerning risk behaviour in the post-crisis situation (Crosby, 1997; Crosby, 1998; Kegeles et al., 1988; Kok, 1999; Marks et al., 1992; Niccolai et al., 1999; Wolitski et al., 1998a; Wolitski et al., 1998b). For example, a researcher noted that: "... it is also necessary to develop prevention strategies for people with HIV infection who experience difficulty protecting their partners" (Kalichman et al., 1997: 447). Others have articulated this sense of responsibility in stronger terms:

There is a responsibility issue here. The solution needs to come from within the community, and especially from within the community of HIV-infected people. It is up to us, the HIV-infected, to take charge of this issue as we have taken charge

of our disease, and let the infection stop with us (Russell, 2000).

This quotation summarises the various preoccupations of prevention altruism. It concerns the cultivation of responsibility among people with HIV in an effort to contain HIV transmission. It also relies on a general notion of collectivity or some idea of a community of HIV positive people. ‘The HIV-infected’ apparently comprise a kind of public health constituency. Prevention altruism therefore refers to a sociality informed by medical ideas about identity and social organisation.

This notion of prevention altruism has become a major theme of policy discourse. A review paper in the leading medical journal *AIDS* outlined a programme of intervention about the risky behaviour of people with HIV (Marks et al., 1999). They recommended several forms of behavioural and legislative intervention, including anti-discrimination policies to protect people with HIV in health care. They also recommended strategies to: “... promote norms of responsibility and protection of others in sexual matters” and “... foster the perception that HIV is still a life-threatening disease despite medical advances in treating it” (Marks et al., 1999: 303). These analysts saw virtue in promoting the responsibilities of the person with HIV with little reference to those of their sexual partners. There is also a kind of recursive effect in the idea that HIV should be portrayed as life-threatening to counteract any tendency for treatment optimism to erode commitment to safer sex. This is an extension of the treatment optimism thesis discussed in chapter two. It would seem that people with HIV are asked to encounter a paradox. For the purposes of HIV prevention, people with HIV are expected to negate the hopes that mobilise the value of biomedicine in the management of HIV. This negation may have effects in ontological security for the individual in terms of the curative qualities of medicine. This self-negation also seems to reflect an ethical

judgement about how the person with HIV should engage with the risky aspects of HIV and medicine. These problems of negation are reminiscent of Macintyre's observations that biomedicine inadvertently undermines the ontological security of people with HIV in its accumulation of evidence about life expectations (1999). It seems that, as with treatment per se, an exercise of preventing HIV transmission leads into some problems for the reflexive self. The required self-negation and reverberations in ontological security could be taken as an example of an iatrogenic effect of HIV prevention.

Despite limitations, research and policy has taken up the idea of encouraging altruism and focusing on people with HIV. In 2001, the US Centres for Disease Control launched their new HIV prevention approach (Janssen et al., 2001). In this approach, a serostatus hierarchy is used to structure intervention strategy. For example, the programme is explained in this way:

At a time of increasing risk behaviour in some communities with high HIV prevalence and among an increasing number of individuals with HIV infection, SAFE strategies for HIV-infected individuals represent a logical evolution of prevention in an era of improved treatment. Such an approach couples a traditional infectious disease control focus on the infected person with behavioural interventions that have become standard elements in HIV prevention programmes. In this new era, for individual as well as public health reasons, every person with HIV should be voluntarily diagnosed, evaluated medically, treated according to state-of-the-art guidelines, and provided appropriate prevention services (Janssen et al., 2001: 1023).

This CDC prevention method follows a public health approach of directing action at the source of disease. In line with this policy focus, researchers have investigated how

beliefs of responsibility relate to patterns of disclosure with casual partners among gay men with HIV (Serovich & Mosack, 2003). A recent US multi-city campaign was called 'HIV stops with me: prevention for positives marketing campaign' (see: www.hivstopswithme.org). The campaign used a mix of peer education, information materials and personal testimonials to increase self-efficacy, reduce stigma and promote safer sex among people with HIV. The underlying strategy of the campaign was the containment of the epidemic by bolstering responsible and altruistic action on the part of individuals with HIV.

This reliance on the idea of altruism on the part of people with HIV has some precedents. Following Titmus, Berridge has explored how the UK blood supply both reflected and was protected by the reciprocal relations of medical altruism (Berridge, 1996). The blood supply in the UK was based on donation, on the principle of individual contributions of blood that benefited society, an act that carried with it an implication that the donor could also benefit from the donated blood supply if need be. Berridge argued that when the risk of HIV infection of the blood supply became a fear in the late 1980s, altruism was also used as a way of preserving the blood supply. People at risk of HIV were asked to opt out of making donations. It seems that for quite some time and in connection with health care in general, HIV risk management has relied on a kind of medical altruism.

Altruism has also been a method of risk management for people with HIV providing health care. Small analysed governmental responses to panic about the discovery of HIV positive health-care workers in the UK health system (Small, 1996). Small described how UK policy was based on a form of 'required altruism', where HIV positive health-care workers had to absent themselves from medical situations and practices that might

have transmitted HIV. A policy of altruism was seen as more humane than coercive (and impractical) detection and banishment. Small showed how altruism also had the virtue of defending medicine. Altruism had the benefit of making the individual health care worker personally responsible. To fail to act responsibly was not a failure of medical institutions or the practice of medicine in general, but of the individual practitioner. Small's analysis reminds us that altruistic management of the risks of sexual practice is a kind of responsabilisation of gay men with HIV that has a genealogy in a general medical approach to risk management. Following Small's analysis, altruism makes each person with HIV singularly responsible for managing the risks of HIV. Those who fail to carry out their responsibilities become a preoccupation for public health, an interest that draws attention away from the social setting of risk and the manufactured uncertainties of post-crisis. Small also noted how a policy of compulsory altruism on the part of HIV positive health care workers may have discouraged openness about serostatus identity. By extension, compulsory altruism applied to the sexual practice of gay men with HIV may have a similar effect.

Another aspect of altruism concerns how it divides the labour of safer sex. Research about women with HIV and safer sex has explored unequal power in sexual relationships and the 'feminisation' of responsibility for condom use (Crawford et al., 1997; Hankins et al., 1997; Ingram & Hutchinson, 2000; Lather, 1995; Lawless et al., 1996). The research also refers to the difficulties faced by women in exercising control over their own bodies without having to take on complete responsibility for contraception and safer sex. Feminisation of the work of safer sex also reflects the gendering of sexual meanings, where male sexuality, or more specifically, the male body in sex, is constructed as beyond rational control (Connell & Dowsett, 1999; Marshall, 2002). Required altruism on the part of gay men with HIV has similar effects.

The responsibility for preventing HIV falls on the gay man with HIV. It also requires that the gay man with HIV somehow contain or transform his body so that it becomes controllable and therefore amenable to safer sex. Altruism therefore sits in opposition to the construction of the male sexual body. Gay men with HIV are asked to step outside this ordering of the male sexual body in the interests of HIV prevention. In addition, because altruism is applied to people who know they have HIV, those who do not think they have HIV are therefore free to act. It is therefore perhaps not surprising that some gay men with HIV report problems with sexual function linked in part to treatment itself (Colson et al., 2002; Dukers et al., 2001; Imrie et al., 2002; Oette et al., 2002). Altruism, articulated as it is with serostatus and sexual agency, helps constitute unequal relations in the work of safer sex.

Research also suggests that people with HIV are unequal in sexual relations. Quantitative research has suggested that a majority of gay men who are not infected expect their HIV positive partners to disclose their HIV status prior to sex (Reid et al., 2002). Qualitative research has also suggested that HIV serostatus brings about unequal responsibilities in risk management, where the person with HIV was seen to have extra responsibilities to do with their serostatus (Davis, 2002). Other researchers have suggested that people with HIV, through a "... cruel twisting of logic" can be held to blame for the risk of HIV transmission even when the other partner decided to have sex without condoms (Cusick & Rhodes, 2000: 481). These kinds of social expectations in risk management are reminiscent of an aspect of Douglas's cultural theory of risk:

To be 'at risk' is equivalent to being sinned against, being vulnerable to the events caused by others, whereas being 'in sin' means being the cause of harm (1992: 28).

This sense of the "... cause of harm" reflects a mingling of an epidemiological logic of the cause of transmission and moral responsibility. For this reason, sharing knowledge about HIV serostatus has both social and prevention significance. Qualitative research has shown that these questions of responsibility translate into deciding whether or not, or how, to disclose HIV status with a sexual partner (Keogh et al., 1995). This practice was shown to be problematic, either if disclosure was achieved, or if it was not. People faced rejection and an intensification of responsibility for the safety of sexual interaction if they disclosed. If people did not disclose, they faced negative feelings such as guilt. Keogh et al's research also suggests that the settings of sexual relations are important (1995). For example, casual anonymous sex was seen as a situation that did not require disclosure and where sexual risk was an individual responsibility. However, in the situation where a casual sexual contact turned into a more regular and emotionally important partnership, men faced a dilemma of when to tell if they had not done so at the outset. It seems that in practice, gay men with HIV find that the sharing of responsibility in sexual relations is unequal and that risk management responsibility is a practice of contingency management in the practice of sexual relating with moral, emotional and viral implications.

Taking up the challenges of required altruism and 'sero-inequality' in HIV prevention, community-based organisations have developed a different approach to the HIV prevention responsibilities of people with HIV. The National Association of People with AIDS (NAPWA) in the US have formulated a set of guidelines for effective prevention among people with HIV (see: www.napwa.org). In particular, the NAPWA guidance places emphasis on the autonomy of people with HIV and the need for cooperation as the basis for effective HIV prevention. As such, the guidelines reflect how people with HIV organise collective resistance to unwelcome categorisation and the reduction of

autonomy (Herdt, 2001; Parker & Aggleton, 2003). Through the sharing of responsibility in sexual partnering, the guidelines also help us to recognise how collective and individual action can be combined in HIV prevention work. In addition, the guidelines define sexual health in terms of the capacity of people with HIV to be able to articulate their needs and act on them.

Altruism would seem to be an important form of governance with special application in the post-crisis situation. However, stronger sanctions on conduct have emerged in the form of detainment and criminalisation. These changes may be an aspect of post-crisis because it appears that they are predicated on the paradoxical assumption that HIV infection is less serious, but not altogether without significance. In various legal contexts people who knowingly transmit HIV can be detained (Carlson, 1989; Gibson, 1997). In Scotland and England, people have been prosecuted for knowingly infecting partners with HIV, or risking their infection (Carter, 2004; Scott, 2001). In the Scottish case, the man's HIV-test counsellor was subpoenaed to provide evidence that the defendant was aware of the risks of sexual intercourse once he had found out about his infection. This information was therefore used to substantiate the case against him in terms of knowingly infecting his partner. In the English case a man was jailed for unintentional but 'reckless' HIV transmission (Carter, 2004). One legal researcher has used the idea of 'proportionality analysis' to understand this changing social and legal situation (Harrington, 2002). Prior to HAART and therefore in the situation where people with HIV infection were likely to die and faced stigma and social rejection, HIV prevention relied on autonomy on the part of those with HIV because more coercive interventions were regarded as inhumane. But in post-crisis and presumably where HIV infection is less serious (but not altogether unproblematic), there is a move to more coercive interventions regarding HIV prevention because they are seen as

‘proportionately’ less punitive. Another legal analysis also underlines the moral jeopardy faced by people with HIV in their sex lives in the post-HAART situation (Ainslie, 2002). The application and tightening of legal sanctions are predicated on the sense that, because of treatment, HIV is less serious, medically and socially. But neither is HIV infection inconsequential, as it remains a serious legal matter. This ‘in-between’ quality of post-crisis situation has significant implications for the legal standing of people with HIV.

The post-crisis situation is therefore informed by a duality of required prevention altruism and legal sanction. In other terms, this duality is a mixture of self-discipline and external forms of compulsion. The autonomy of people with HIV is therefore limited. People with HIV are free to act but only if they do the right thing in terms of HIV prevention. In this light, the promotion of altruism among gay men with HIV emerges as a complex form of social intervention. Altruism is required, but at the same time it is set against more coercive legal sanctions on behaviour that can transmit HIV. It is as if the positive cultivation of altruism is a way of deflecting the need for more coercive interventions such as detainment and prosecution. And together, required altruism and sanctions reveal that post-crisis risk governance is concerned with the containment of HIV transmission in connection with the growing numbers of people with HIV. In this view, the effects of treatment optimism on risky sexual behaviour become less important. In the post-crisis situation, risk governance is interested in HIV treatment mostly in terms of how it increases the presence of people with HIV in society and how the treated conduct themselves.

Post-crisis transgressions

The requirement of altruistic conduct articulates with what can be called ‘transgressive’

sexual practice. The news media and gay men's magazines have carried stories of parties for sex without condoms or other forms of transgression of safer sex, reflecting a discourse about the unruly gay man in the post-crisis situation (Rofes, 1999). This discursive construction of transgressive sexual practice can be traced into the gay magazine article about "barebacking" introduced in chapter one (Signorile, 1997: electronic source). This article revealed a striking resonance with the post-crisis situation. It referred to an online chat with a gay man about his desire and intentions for risky sex. The article discussed also the man's apparent lack of awareness of his own HIV serostatus and his perspectives on the prospect of HIV infection in light of effective treatment. Apart from its reference to barebacking and the Internet, the article combined the idea of the unruly gay man, risky sex and treatment. Moreover, this post-crisis pastiche was achieved in 1997 just twelve months after the so-called protease watershed. Since that article was published, barebacking has 'morphed' into several forms of transgressive practice with different implications for HIV transmission:

"... seroconversion parties", "... Russian roulette" (Cairns, 2000),

"... consciously, wilfully and proudly engage in unprotected anal sex, also skin-on-skin" (Sheon & Plant, 2000),

"... barebacking represents a conscious, firm decision to forgo condoms and despite the dangers, unapologetically revel in the pleasure of doing it raw" (Scarce, 1999),

"... negotiated risk" (Scarce, 1999),

"... the practice of pos men intentionally having unsafe sex with other pos men, a practice known as barebacking" (Halkitis, 2000).

Other constructions include 'bug-chasing' and 'gift-giving', terms applied to men who seek infection or who 'give' it (Laza, 2003). Importantly, some media stories have slid

between unsafe sex between gay men with HIV to gay men with HIV spreading the HIV virus (Wells, 2000).

Researchers have also engaged with this idea of transgressive sexual practice on the part of gay men. In the main, these researchers appear to have taken on the discourse of barebacking unquestioningly, and articulated a research domain about social deviance and the notion of the intractable risk-taker. Such research seems to have also left out any sense of how gay men might seek to moderate the risks of anal sex without condoms. Barebacking is therefore taken to represent a kind of literal resistance of HIV prevention guidance and has been used to revive psychological theories such as 'reactance' (Crossley, 2002). For some researchers, the practice of barebacking is regarded as a challenge to orthodox forms of HIV prevention and therefore represents a failure to engage with gay men (Goodroad et al., 2000). Barebacking has also been addressed as social deviance (Gauthier & Forsyth, 1999), and psychiatrists have attempted explanations of barebacking in terms of cathexis (Carballo-Diequez, 2001).

However, it can be argued that the notion of barebacking is a more subtle form of resistance. For example, barebacking can be couched in terms of freedom and as legitimate choice, particularly between gay men with HIV (Gendin, 1999a; Gendin, 1999b). In this form, barebacking is seen to be a release from constraint. Epidemiologists have reported that gay men with HIV use the Internet to find other HIV positive partners (Bolding et al., 2004). In sex without condoms with HIV positive partners, gay men with HIV may find respite from the post-crisis HIV epidemic. The positive to positive serologic of some barebacking is a feature that is often overlooked in discourse about resistance of HIV prevention guidance (Crossley, 2002). There is also an important connection here with HIV treatment and the contestable qualities of risk

calculus. In particular, barebacking between men with HIV may not be seen as a significant health problem. In this regard, the tension in the discourse about barebacking connects with contest over how to engage with the effects of treatment in the management of the epidemic.

The idea that barebacking can be a form of transgression and that it forms a system of governance with required altruism suggests governmentality. Foucault brought sex and medicine together in the notion of “biopower” (Foucault, 1978: 139). Through biopower, sex and medicine were joined in positive production: “... sex was a means of access both to the life of the body and the life of the species” (Foucault, 1991: 267). The bringing together of sex and medicine in governmentality also creates a medical interest in ‘technologies of sex’:

a political ordering of life ... provided itself with a body to be cared for, protected, cultivated, and preserved from the many dangers and contacts to be isolated from others so that it would retain its differential value; and this, by equipping itself with - among other resources - a technology of sex (Foucault, 1978: 123).

This ‘technology of sex’ locates the individual in sexual relation with others, creating a method for a discursive ordering of the proper separation and combination of sexual bodies. In terms of HIV, relevant technologies might be required altruism and its counterpoint, barebacking. Together they are two sides of a system concerned with the governance of reflexivity concerning HIV prevention. In this light, the post-crisis contest about responsible conduct emerges as a logic of ‘techno-sexual’ hygiene.

It seems that barebacking discourse and altruism form a system of correct sexual

conduct for the post-crisis era. To take this point a little further, contest about responsible conduct leads to other questions about the treatment optimism thesis. The idea that treatment optimism could lead people to abandon safer sex may be part of a larger system of governance, in particular, about the treatment-related choices that people make. As I discussed in chapter two, the risk implications of reinfection are a form of manufactured uncertainty and they are contentious and debated as a matter of technical knowledge. Via this contest over responsibility, HIV prevention in post-crisis is not so much about behaviour and how it is influenced by perceptions and beliefs of treatment-related risk knowledge, but more about a politicisation of the choices that people make about risk in the situation of uncertainty and debate. The articulation of barebacking with altruism underlines this widened sense of post-crisis risk governance. The associated legal sanctions on risk practice also suggest an ethical field rather than the medical determination of behaviour. The transgressive and resistive properties of barebacking discourse reveal an alternative ethical framework of risk concerning treatment and sexual relations. We know little about these ethics because, as mentioned in chapter two, for the most part gay men with HIV have been approached with forced choice surveys about their treatment expectations and sexual practice. There is then ample scope, and arguably urgent need, for in-depth inquiry about these subaltern ethics of post-crisis risk management.

Responsible action and sexual community

The ethical considerations of risk management choices also suggest community relations. Altruism in particular, figured as it is around the idea of "... us, the HIV-infected" connotes responsibilities towards the health of a community (Russell, 2000). But this conceptualisation of community refers to a medical imaginary of identities and social action. An alternative perspective is available in the writing of those who have

addressed the idea of living with HIV in a sexual community and risk management as collective practice. Weeks has discussed how the invention of safer sex marked a form of social organisation of: "... the need for both individual fulfilment and for mutual involvement" (Weeks, 1998: 44). Weeks has suggested that the HIV epidemic made responsibility imperative in a culture that valued sexual autonomy:

But the most striking feature of the response to the epidemic from the gay community was the way in which it brought out a new culture of responsibility. for the self and for others (Weeks, 1995). The discourse of safer sex is precisely about balancing individual needs and responsibility to others in a community of identity whose organizing principle is the avoidance of infection and the provision of mutual support But in turn AIDS has raised complex issues about citizenship, and especially about the degree to which the execrated and threatening person with a life-threatening syndrome who nevertheless fails to engage in 'safer sex' can be fully included in the social (1998: 44).

In this depiction of the sexual citizen, Weeks brings together autonomy and the building of sexual communities that exceeds the more individualising prevention altruism. In this he also suggests the interdependency of responsibility and community and raises a question about the place of the person with HIV. Differing with Weeks, Crimp has argued that gay community responses to HIV and AIDS were possible because of how such communities constituted themselves: "... AIDS didn't make gay men grow up and become responsible. AIDS showed anyone willing to pay attention how genuinely ethical the invention of gay life had been" (2002: 16). Crimp's argument is also couched in terms of a response to the neo-conservative gay movement in the US and a discourse that the HIV epidemic is a consequence of the irresponsibility and immaturity of gay men. His analysis suggests that arguments about responsible conduct involve

community politics. Weeks and Crimp also gesture towards the ethical dimensions of sexual intimacy in connection with HIV risk.

In ^{one} respect, the prevention altruism responses to HIV risk such as the idea that interventions should "... promote norms of responsibility and protection of others in sexual matters", are constituted inside these arguments about the ethics of sexual intimacy and risk (Marks et al., 1999: 303). In particular, Crimp's perspective about the politics of sexual responsibility in the United States suggests that the imperative of altruistic conduct may also be part of these politics. For instance, most of the public health policy developments concerning altruism originate in the United States. But in light of the community perspective, and despite possible origins in arguments about responsible social action in sexual community, these public health responses are individualising. For example, a study of UK HIV prevention materials revealed that they mainly addressed individual responsibilities and did not make enough of the idea of shared responsibility (Dodds, 2002). It was suggested that intervention designers had not engaged with the connections between personal responsibility and the building of safer sex as a community practice. It appears that the social practice of safer sex responsibility emanates from, and requires, some kind of ethical construction of 'person in society'. Without this sense of ethical community practice, interventions collapse into a focus on atomised individuals. These perspectives also signal that, for the person with HIV, identity and community are at stake in the articulation of HIV prevention responsibility.

But there is also a wider argument about altruism and collective action. In a different context, Beck has foreshadowed a kind of "... altruistic individualism" in an around the construction of sexual intimacy in late modernity (Beck & Beck-Gernsheim, 2002: 212).

This form of altruism is the basis for ethical practice:

Out of the struggle with this dilemma between love and freedom a new ethics will emerge about the importance of individuation and obligation to others. No one has the answer as to how this will work (Beck & Beck-Gernsheim, 2002: 212).

This form of altruism for Beck is a pure, unfettered form of mutual ‘care for others’ and implies social equality. The notion also appears in the epilogue of his book, *Individualisation* and he admits the idea of ‘altruistic individualism’ is poorly articulated and that there is scope for “... a lot of dilemmas and paradoxes” (Beck & Beck-Gernsheim, 2002: 212). The idea that gay men with HIV can and should always act in an altruistic way may be such an example. But, for altruism to be viable as a method of HIV prevention there needs to be equality in sexual community. As I have outlined using theoretical and qualitative research about gay men with HIV and their sexual practice, the notion of the “... cause of harm” and its implied moral responsibilities and identities of ‘sinner’ and ‘sinned against’ may limit mutual altruism in sexual relations (Douglas, 1992: 28).

Security and trust in sexual relations

There is then research and theory to suggest that risk management for people with HIV raises questions about the carriage of the moral self in sexual relations. It seems possible therefore to argue that the HIV prevention responsibilities for people with HIV imply the need to address social relations. As I noted in chapter two, the relational aspects of risk management are definitely marginal to the treatment optimism thesis. Similarly the favoured risk reflexivity perspective can be advanced by making some connections with the relational aspects of sexual practice and risk management. In addition, most of the theoretical work about responsibility, sexual community and the moral self pertains to the period of the epidemic prior to the advent of treatable HIV. For example, the

qualitative research about how gay men engage with the relational aspects of HIV prevention was mostly done prior to the advent of treatable HIV (Cusick & Rhodes, 1999; Cusick & Rhodes, 2000; Rhodes, 2000; Rhodes & Cusick, 2000). As I suggested in chapter two, the few researchers who have engaged with the advent of treatable HIV and risk reflexivity have made scant reference to its moral and relational connotations for people with HIV infection (Flowers, 2001; Race, 2001; Rosengarten et al., 2001). There is then ample scope for developing the idea of risk reflexivity for the post-crisis era, with reference to the social aspects of the sexual relations of gay men with HIV.

Giddens's articulation of reflexivity has much to say about risk and intimate relations. Moreover, there is reason to suggest that for gay men with HIV living in the post-crisis situation, security forms a point of continuity between sexual relations and treatment itself. In chapter two, I identified that narrative research about the HIV experience has noted the various threats to ontological health for people with HIV and also some of the post-crisis ramifications for reliance on treatment and its related medical technologies. Giddens has argued that in reflexive modernisation, intimate relations also have importance for security. In the absence of traditions that might provide the basis for a way of life, it is held that individuals rely on various "... abstract systems" such as the regulation of time and financial systems, as well as science and technology. In the reflexive production of the self, trust in abstract systems takes on central importance as a basis for ontological security, or a personal sense of "being-in-the-world" (Giddens, 1990: 92). In risk society where there is a special significance for the self-made biography, the intimate and specifically sexual relationship, is a source of what Giddens calls "self-actualisation" (Giddens, 1990: 124):

Erotic relations involve a progressive path of mutual discovery ... personal trust, therefore, has to be established through the process of self-enquiry: the

discovery of oneself becomes a project directly involved with the reflexivity of modernity (Giddens, 1990: 122).

In the situation of reflexive modernisation, intimate relations take on importance as a basis for self-knowledge found in the security achieved in relationships of trust. There is also another connection between the security of the reflexive self and a wider sense of the impact of medical technology. Giddens has suggested how changes in reproductive technologies have been linked with changes in heterosexual partnering and as he terms it, a release into the pleasures and intimacies of the pure relationship where: "... the plasticity of sexual response is channelled above all by a recognition of the tastes of the partners and their view about what is or is not enjoyable or tolerable" (Giddens, 1992: 143). In this notion of plastic sexuality, the freedoms afforded by medical technologies mean that sexual pleasure and intimacy become methods of negotiating and achieving a sense of self.

Some of the 'pre-treatment' research has explored this idea of intimate relations and security for people with HIV. Researchers have explored reflexivity and sexual relations with young people (Lupton et al., 1995; Lupton & Tulloch, 1998) and among people with HIV (Cusick & Rhodes, 2000; Rhodes & Cusick, 2000). These researchers have argued that HIV prevention strategies like condom use may come to interfere with intimate relations as a method for describing the self and therefore for security. For example, condoms can come to be seen as a barrier to intimacy. But for the reflexive self, this obstruction of security is not only a matter of pleasure: it is deeply implicated in the quest for securing the self in intimate relations and therefore in risk society. In this situation, trust may come to stand in for condom use. In the absence of condoms, people will determine that they can trust the other person to not expose them to risk. People

who have HIV infection may find that they are entrusted with minding the risks for their sexual partners. But in this quest for security through the removal of barriers and mobilisation of trust, HIV transmission becomes a possibility (Rhodes, 2000). Intimate relations therefore are a source of security but at the same time create forms of risk.

It also seems that, for people with HIV, trust has other social uses. As I have discussed, UK public health policy about HIV positive health care workers has relied on altruism. But the self-subjection implied in altruism is a kind of trust. As discussed, in the early years of the HIV epidemic, individual health care workers with HIV were relied on to voluntarily opt out of medical practices that provided a risk of transmission of HIV (Small, 1996). Trust is typically seen as an aspect of reflexivity where the self relies on abstract systems to manage the life course and, for the present purposes, risk (Giddens, 1991). But through required altruism, trust helps secure medicine in the action of individuals. In the present example, health care workers are entrusted with acting in an altruistic way for the purposes of managing HIV risk in medical interventions. Risk management in medicine therefore emerges as reflexive because it depends on the trust relations of health care workers with the expectations that inform their professional practice. By extension, trust relations are also relevant for systems of risk management in sexual practice. Although not ostensibly addressed by those researchers who established the concept, trust is an aspect of the idea of negotiated safety discussed in chapter two (Kippax, 1993). Even with synchronous HIV testing to prove concordant HIV negative or HIV positive serostatus, the ongoing safety of the relationship is predicated on trust that one's partner will not jeopardise monogamy and an agreement of how to avoid HIV infection. Finding a trustworthy partner is also implied in public health advice figured around monogamy as a sexual health strategy (Brown, 2000).

Clearly, responsible HIV prevention action takes place in and through sexual relations. It therefore requires trust relations and implies personal security. However, we know very little about how gay men with HIV in the post-crisis situation, themselves account for the management of HIV transmission with reference to security and trust.

Reflexive treatment in the post-crisis situation

The combination of required altruism and transgressive barebacking suggests that post-crisis risk governance is informed by a contest about responsible conduct with reverberations in the construction of sexual community, security and trust relations. The idea of contest also forces a switch in thinking about risk reflexivity and HIV treatment. Orthodox constructions of post-crisis discourse are informed by a kind of technological determinism. The idea of changed life expectations associated with the advent of treatable HIV sponsoring changes in risk behaviour, implies an ordering of the material over the social. For example, treatment optimism research implies that treatment changes risk behaviour much as it changes the life cycle of the HIV virus. However, contest suggests that post-crisis is less about how treatment determines risk practice and more about how HIV treatment is to be governed. The question of the relationship between technology and society has been considered by others. Beck has written of the relationship between society and technology as a kind of spiral: "... technology may be seen as a spiral-like process. It appears as both the product and the instrument of social needs, interests and conflicts. Technology is effect and cause at the same time" (Beck & Beck-Gernsheim, 2002: 139). Bruno Latour, often portrayed as a significant thinker in science and technology studies, has written about hybridity in connection with the mixing of technology and society (Latour, 1993). In his vast elaboration of the *Network Society*, Castells suggests that the effects of information technology cannot be separated from the "... historical specificity of social practices" that produce them (Castells, 2000:

441). These perspectives imply that HIV medical technology needs to be understood in connection with the situated social practices that mobilise them in terms of both meaning and effects. In this view, HIV treatment is constituted in the practices of people with HIV. In a banal sense, treatment is inert until it enters bodies and populations and therefore into human agency. In this light, taking HIV treatment becomes a significant action of the reflexive self. Therefore it is possible to say that the advent of treatable HIV and the post-crisis situation are made as a matter of the reflexivity of 'techno-selves' with implications for how we conceptualise risk reflexivity in connection with treatment and sexual practice. In the following sections, I consider how others have written about this notion of reflexive treatment. First, I outline the contribution of research about HIV treatment advocacy which has concerned itself with contesting the terms of treatment science and the politics of literally getting treatment into bodies. In the next few sections, I consider several critiques of risk reflexivity to do with power, aesthetic reflexivity and moral hierarchy. In the last section, I explore research about HIV treatment and related medical technologies in connection with the construction of post-crisis selves.

The legacy of HIV treatment advocacy

Prior to the advent of treatable HIV, access was one of the central questions of HIV treatment. Treatment advocacy projects were therefore a pronounced aspect of community-based responses to HIV (Epstein, 1996). These projects focused on overcoming bureaucratic and scientific barriers to any possible treatment that might have had some beneficial effects. The advocacy movement also involved the promotion of the involvement of people affected by the epidemic in how treatment science was managed. As such, the advocacy movement revealed a concern with governing access to treatment and how it was to be used.

Reflecting on treatment advocacy politics and making connections with the post-crisis situation, Treichler has argued for "... a radical and democratic technoculture" (1999: 280). By this, Treichler means a form of active engagement with medicine on the part of people affected by HIV, to further access to, and enhance influence over the use of treatment. For instance:

... the strongest challenge to current conditions comes not from those who dismiss or denounce technology but rather from those who seek a more progressive, intelligent, and participatory deployment of science and scientific theory in everyday life The strength of their guiding theoretical frame lies not in a resistance to orthodox science but in strategic conceptions of "scientific truth" that leave room for action in the face of contradictions. This makes it possible to seek local, partial solutions and to give more attention to difference and diversity (1999: 298).

Treichler's viewpoint is a kind of reflexive treatment. It depicts a form of medicine, made and applied by people affected by HIV in the interests of their own survival. Treichler also implies that intervention in HIV treatment requires an elaboration of forms of participation in knowledge-making about biomedicine, but without relinquishing the capacity to contest truth-making criteria and practices. It does seem possible to hold that to some extent a techno-democracy has been achieved in the area of HIV. Epstein has shown how scientific knowledge production about HIV has been subject to the influence of the interests of affected communities (Epstein, 1996). Examples include the invention of safer sex and the participation of people with HIV in the management and dissemination of information about the clinical trials of treatments. Democratisation of HIV medicine then is seen as a basis for articulating forms of social

relations that construct and redistribute knowledge in desirable ways, and by implication, including those that pertain to post-crisis risks.

But Epstein also raises a cautionary note. While activism has helped to reconfigure some aspects of HIV medicine, several forms of counter-medicalisation may also occur. In terms of the medical objectification of identity, some concerns about representation and the refiguring of activism (Epstein, 2000). Epstein notes how in an effort to influence how HIV medicine is done, activists themselves have been drawn into medical systems of authority and expertise, creating new divisions or a kind of “expertification” and “... hierarchies of expertise” that may be shaped around, and therefore help to reproduce, health inequalities related to class, gender and ethnicity (Epstein, 2000: web document). He also suggests that the activist inspired focus on the health needs of marginal populations, mostly figured around these categories of class, gender and ethnicity, has a possible unintended by-product of the objectification of such groups in medical terms, creating the prospect that social inequality comes to be understood as a matter of biology. This aspect of medicalisation leads into a kind of reification of identity categories in medical terms, a process that folds back onto HIV activism to create problems for claims around representation and the experience of HIV and the general project of influencing HIV medicine in desirable ways (Epstein, 2000). This recursive medicalisation is a challenge for the idea of techno-democracy, as it suggests that activism, in the effort of reshaping the articulation of reflexive treatment, returns us to forms of exclusion. This medicalisation of social categories also seems to be a problem if a democratic form of reflexive treatment is enacted without an epistemological edge. Treichler does note that treatment advocacy needs to acknowledge the provisionalities of the knowledge-making practices of science. But Epstein’s account reveals an idealised thread in techno-democracy. In his account there

is an unresolved matter of the tensions between the democratisation of medicine and the medical ‘colonisation’ of the social.

Others have taken the view that there can be no straightforward engagement with medicine or medicalisation when medical authority is itself in crisis. Instead it is held that AIDS “focuses” a “... general panic or cynicism toward the power of orthodox medicine” (Erni, 1992: 42). Following this perspective, medicalisation is bound up with discourse and counterdiscourse regarding the “... healing power” of medicine (Erni, 1992: 53). This perspective seems consistent with the idea that the riskiness of HIV is derived from its (in)curability that both decentres medicine but mobilises hopes for a biomedical solution (Delvecchio-Good, 2001). Erni writes of a kind of dialogue through which the terms of the relationship between medicine and society are worked out:

My thesis is that the politics of the treatment of AIDS – indeed, the politics about how the ending of the AIDS story will be constructed – is located in the strategic articulation between two contradictory discourses: a “discourse of impossibility” and a “discourse of possibility.” The effect of this is a potential re-emergence of “bio-control culture” (Erni, 1992: 41).

Erni also suggests that responses about HIV are dualistic in that they respond to HIV risk but also to the crisis of trust in biomedicine. Erni envisages a ‘bio-control culture’, which is a kind of interdetermination of society and biology that suggests a contest about how to realise cure both with and through medicine. However, this discourse and counter-discourse also make constructs of medicine seem assembled and therefore resistible.

Another way of thinking about the politics of HIV treatment is humanism. Writing

about technology in general, Giddens suggests a turn to a macro-reflexivity in thinking about technological determinism and agency:

... the logic of unfettered scientific and technological development will have to be confronted if serious and irreversible harm is to be avoided. The humanising of technology is likely to involve the increasing introduction of moral issues into the now largely “instrumental” relation between human beings and the created environment (1990: 170).

Giddens’s perspective suggests that HIV medicine and its effects in lived experience can be addressed by adopting a humanistic stance, something that resonates with Treichler’s techno-democracy. Giddens’s call for a humanising of technology translates into a need to engage with the uncertainties and contests that arise in the post-crisis situation.

These perspectives on HIV treatment serve to underline how the area of HIV is permeated with questions about how the terms of access to and use of treatment and its effects are to be governed. But none of these writers have made much reference to the post-crisis situation and particularly the manufactured uncertainties of HIV medicine or the implications for the sexual practice of gay men with HIV. It is possible however to speculate that post-crisis risk governance is open to democratisation and humanistic ethics, but also medicalisation and ‘bio-control’. And in the advent of treatable HIV in the affluent West, these questions of governance have, in part, transferred from advocacy and access to managing treatment through a contest about the responsible conduct on the part of gay men with HIV.

Power and reflexivity

But techno-democracy and humanism also imply a domain of free action for the

reflexive self, a polity open to dialogue and that can achieve change. But as I have discussed, questions about how HIV treatment is to be governed remain unsettled, conferring on the post-crisis situation a sense of contest and the limitation of free action. In particular, required altruism and legal sanctions imply that people with HIV are free to choose only the 'right' thing. The idea of a free, reflexive self has been questioned by others. Researchers have identified cultural explanations of risk and risk-taking and therefore questioned the idea of a voluntaristic, 'psychological', reflexive self (Douglas, 1966; Douglas, 1992; Douglas & Calvez, 1990; Lupton & Tulloch, 2002a; Lupton & Tulloch, 2002b). Rose has also made the point that the subject of late modernity is "obliged to be free" implying that reflexivity is governed as a matter of power (1989: 217).

In the interests of elaborating on power and reflexivity, a subtle contrast can be made between Giddens's notion of the reflexive self and Foucault's notion of self-subjection, each of which resonate with the notion of the sexual self. Giddens works from some notion of a self-regulating individuality in trust relationships with abstract systems. In self-subjection, there is an interest in the knowledge, practices and discursive strategies that help "... to constitute, positively, a new self" (Foucault, 1988: 49). For different reasons, the idea of erotic love is important to both reflexivity and self-subjection. Self-discovery in intimate relations for Giddens and hermeneutics of the self for Foucault, were respectively, features of elaborations on the reflexive construction of self and the entry point to thinking about governmentality. As already discussed, for Giddens the sense of self in the world is in part found in "... erotic relations" (Giddens, 1990: 122). In terms of risk reflexivity, intimacy is a method of "... the discovery of oneself" in late modernity (Giddens, 1990: 122). For Foucault, the exploration of the discursive construction of sexuality, and specifically the 'incitement to discourse', led into an

elaboration of a "... hermeneutics of the self" (Foucault, 1988: 17). This relay extended into "... truth games related to the specific techniques that human beings use to understand themselves" (Foucault, 1988: 18). This sense of self-subjection is evident in Foucault's account of Marcus Aurelius's letter to his lover regarding the physical and mental benefits of his rural retreat (Foucault, 1988: 28 and 29). Aurelius's letter was constructed as a method of self-regard, confiding in the beloved various reflections on the methods of the cultivation of the self. It is striking that a point of separation between the reflexive self and self-subjection can be found in how each perspective relies on some notion of erotic relations. There are several implications. Giddens's approach to reflexivity is not disciplinary as such, creating questions about how his version of reflexivity articulates with power. In particular, in the present case, there is a question about how to construct a project of reflexive treatment that engages with medical power. In addition, the reflexive and disciplinary applications of the notion of erotic love underline the social importance of self in sexual relations for gay men with HIV.

Also providing a critique of reflexivity, Lash has suggested a certain "imperialism of reflexivity" where agency is assumed to be freed from constraint, but where there are questions about whether this is the case (1993: 20). Lash has also made a distinction between reflexivity and disciplinary power:

What appears as the freedom of agency for the theory of reflexivity is just another means of control for Foucault, as the direct operation of power on the body has been displaced by its mediated operation on the body through the soul (1993: 20).

These concerns over agency and constraint have been taken into research about HIV. Heaphy has considered the "... the limits to reflexivity" brought about in the context of

living with AIDS (1996: 157). Heaphy reckoned that: "... we need to account for experiences where AIDS/HIV can appear both to empower and discipline individuals" (1996: 159). The reflexive self can engage with knowledge and expert systems to become better informed about treatment to use it to best advantage. But HIV treatment is also a form of power/knowledge invested in certain forms of the reflexive self:

... it must be acknowledged that while the multiplication of expert systems that mediate different AIDS/HIV knowledges may appear to open up choice, this multiplication may also be indicative of both the expansion of judges of normality and the extension of disciplining discourses (1996: 158).

Heaphy suggests that the proliferation of medical technology in the area of HIV realises an expanding duality of choices and regulatory requirements. The required altruism of post-crisis, the history of treatment advocacy and 'expertification' are examples. Heaphy argues that the advent of treatable HIV requires an understanding of risk that encourages an engagement with disciplinary power.

Adkins has reconsidered some aspects of power and reflexivity in research about HIV testing (2002). Adkins's argument about reflexivity hinges on her rebuttal of one of the main assumptions of the reflexive modernisation thesis: the idea that agency is freed from structure. By making a link with the post-structural idea of mobile subjectivity, Adkins suggests that risk reflexivity helps reconfigure social difference. For example, in research method, reflexivity is often held to be a way of problematising power in research exchanges. Adkins suggests that the kinds of reflexive practice implied in research like this, are only possible because of the mobility of the researcher/author. In this way the researcher emerges in research accounts as the privileged, reflexive identity. In other words, reflexivity is not neutral to power and helps to reconfigure it or

even re-install it. Adkins also argues that HIV testing helps reproduce categories of sexual difference (2002). Apparently, HIV testing among low risk heterosexual people is widespread and growing. Such a situation sits at odds with the idea of a rational project of self-management. This is because risk rationality would suggest that low risk people would not make themselves available for HIV testing. Adkins argues that HIV testing for a likely HIV negative result, is attractive because it reinforces one's identity as low risk and by implication as heterosexual. At the same time HIV testing also works to identify the homosexual and by extension those incapable of correct self-management. Risk reflexivity about HIV testing is therefore not neutral, but power laden. Moreover, Adkins asserts that the "... reflexive subject is the ideal and privileged subject of neo-liberal modes of governance" (Adkins, 2002: 122). I take this to mean that the idea of a reflexive (free) subject has a political purpose. Adkins appears to also want to question the larger risk society thesis that insecurity sponsors reflexivity. For her it is not so much that late modernity has become risk society, but that risk reflexivity is a method of organising late modernity:

... the techniques and practices of risk self-management, that is the techniques of self-reflexivity (such as those made available by the technology of testing) are constitutive of a social order in terms of categories and hierarchies of risk themselves, that is, to make up risk culture (2002: 121).

Taken together, Heaphy's and Adkins's work sponsors a shift into thinking about reflexive treatment in terms of power/knowledge and therefore how it constitutes selves and social relations. In this view, post-crisis becomes a matter of the sorts of identities that come into being as a matter of self-subjection.

Another critique of the idea of an unfettered, reflexive self arises in the notion of aesthetic relations with self. There is an argument that the more ‘calculating’ forms of reflexivity can be distinguished from ‘aesthetic’ reflexivity (Lash, 1993). Lash asserts that there is a hermeneutic aspect in reflexivity which concerns interpretation of the self and that mobilises the expressive/aesthetic. Burchell has also argued for an “... aesthetics of existence” where the technologies of the self and domination are not necessarily completely in symmetrical opposition (1993: 268). Rather, they are seen to be loosely articulated, a situation that gives rise to questions: “... of how freedom can be practised” (1993: 269). This loose articulation has central importance for thinking about risk reflexivity:

It [governmentality] allows one to recognise the agency of subjects, without recourse to a notion of a fully autonomous self or to voluntaristic explanations of behaviour. In the analysis of risk, it shifts the focus from uncertainties and dilemmas associated with individual ‘life-planning’ and ‘lifestyle choice’ (evident in the accounts of Giddens and Beck) to an analysis of ‘practices of the self’ and modes of self-subjection (Petersen, 2000: 203).

It seems that as the assumption of freedom from structure is questioned and slips away, reflexivity begins to take on the governmental meaning of self-subjection. This perspective therefore opens to view, the rules that govern self-subjection. Along with concerns about the psychological problems of reflexivity and security there is a focus on the aesthetic question of how to engage with the requirement of the cultivation of the self.

The aesthetic critique of risk reflexivity raises questions about how to reflect on the

post-crisis situation. In his depiction of reflexive modernisation, Giddens has suggested that the individual is required to: "... ride the juggernaut in hopeful anticipation, [and] never feel entirely secure" (1990: 139). This 'juggernaut' metaphor is a way of describing how the subject of risk society engages with the uncertain qualities of late modernity, a depiction that has resonance with the post-crisis situation and in particular, the manufactured uncertainties of HIV treatment. But this conception of the reflexive self may be an idealisation. This is because this subject of modernity is seen to engage with risk in a way that is unmediated by social difference and therefore power. And this ideal subject of reflexive modernisation is depicted as too actuarial and therefore unable to engage with themselves as a matter of aesthetic production. There is therefore a need to consider whether HIV treatment represents a duality of expanding choices and regulatory requirements. There are also questions over whether the reflexive self is freed from the constraining aspects of treating HIV and how choice figures in discourse about HIV as a method of governance.

Moral selves and hierarchy

Making a connection between risk reflexivity and power creates a focus on the sorts of identities that are required/produced. This question has inspired several researchers working in the areas of health in general and HIV. For example, in an analysis of the management of chronic illness, Galvin has identified some of the negative aspects of neo-liberal constructions of care of the self (Galvin, 2002). According to Galvin: "The search for optimum health has become a kind of pilgrimage, a journey which it is believed will result in the virtuous being rewarded and the guilty having to suffer" (2002: 128). This perspective suggests that healthiness is a moral virtue and a key aspect of the notion of the dutiful "... neo-liberal citizen" (2002: 117). Through the idea of health as a self-made project, the ill and infirm are condemned for having brought

illness on themselves. In this system of meanings, lifestyle becomes an important concept as it reflects the consumption, and therefore moral, choices of the citizen. The lifestyle of the unhealthy therefore becomes a target for regulatory inquiry. In Galvin's analysis, the unhealthy person is responsible for their condition because of the lifestyle choices they have made. Gay men have been found to interpret public health messages about HIV as referring to a risk averse "... model citizen" (Davis, 2002: 292). Men also interpreted risky behaviour in their sexual partners as revealing a self-destructive orientation in the other. Like the condemnation of the chronically ill, risky behaviour was associated with a distinction between virtuous self-care and self-destruction, or a moral judgement attached to the practice of safer sex.

Moral judgements may also serve a hierarchy of risk reflexivity. Lupton has discussed the implications of an economy of reflexive autonomy (Lupton, 1999). In neo-liberal forms of health and social care, those who can exercise self-control in relation to certain risks enjoy continued autonomy. Those who "... lack self-control", are deemed incapable (to lack virtue, to be self-destructive and perhaps a danger to society) and are bracketed out for forms of external and state deployed regulation (Lupton, 1999: 101). This dual system resembles the combination of required altruism and legal sanctions in HIV risk governance. Also considering risk in the neo-liberal state, Castel has suggested that forms of risk administration assign 'at risk' individuals to programmes of risk management (Castel, 1991). In this approach, corrective and therapeutic discipline disappears. Risk science 'projects' destiny as a matter of predictive possibility, classing people according to what objective risk calculations predict for their future: "... the emerging tendency is to assign different social destinies to individuals in line with their varying capacity to live up to the requirements of competitiveness and profitability" (Castel, 1991: 295). Castel argues that risk administration is less interested in

individuals and more interested in flows of risk over time and in populations. This vision of risk provides a possible explanation for the increased value of containment rationality in the area of HIV and the consequent increased focus on the conduct of people with HIV. But importantly, this is not a concern with individuals and the causes of behaviour, but the presence and combination of people with different HIV serostatus.

Lupton has also discussed how the practice of testing for HIV was seen by her interviewees to signify a desirable and prudent management of sexual health (Lupton, 1999). Lupton used the idea of reflexivity to describe how the self-project, and particularly the care of the body, was incomplete. In this sense HIV testers were found to articulate a sense of themselves as ‘becoming’, of perpetually in the making with regard to their sexual health. The idea of the prudent risk subject has a special significance in neo-liberal discourse. O’Malley has taken this idea of prudentialism into the notion of a subject open to a creative engagement with risk, or specifically, how one can profit out of uncertainty (O’Malley, 2000: 478). O’Malley’s analysis reverses the idea of uncertainty as a threat to ontological health and suggests that it can be a resource. This perspective might have application in the area of HIV treatment, where creative applications of reflexivity may be desirable in relation to uncertainty. In a study of people with Huntington’s Chorea, Novas and Rose also described how people were oriented, in a prudent way, to genetic testing, using the test information to think about their future risks of illness and to plan the life course accordingly (Novas & Rose, 2000). Like Lupton, Novas and Rose made an argument for a connection between risk assessment and somaticisation. They used the term “... somatic individuality” to refer to the process whereby genetic tests helped constitute the notion of self at risk through individual microbiological characteristics (2000: 489). In this situation, genetics helped refashion “... personhood along genetic lines” (2000: 485). These studies suggest that

biomedicine is applied in a constructive way by active subjects. At the same time, this project of self is never complete. Care of the self is made possible through medical technology but medical technology has social value as a means to self-governance. And there is an ongoing quality to the requirements of self-care, something that has relevance for people for HIV, particularly in the post-crisis HIV epidemic, which is constructed as a period of chronic manageable illness.

Post-crisis innovations

Race has discussed HIV treatment in post-crisis with reference to risk reflexivity (2001). Race was interested in a critique of HIV medicine, writing that: "... it is necessary to look at how technological change creates and sustains new selves and bodies, new political technologies and institutes an ongoing process of othering" (2001: 177). Race considered how HIV viral load testing can be used to determine if the person has been adhering to their treatment prescription. The viral load test is therefore a: "... tool that links matters of individual and public health" (2001: 168). Joined with the HIV antibody test, the viral load test is therefore implicated in the regulation of the sexual relations of the patient in terms of the containment of HIV. Race's governmental perspective is an important reversal of the treatment optimism thesis. It suggests that aside from questions about whether the risk knowledge provided by medical technologies has a role in increasing risky practice, the same medical technologies are implicated in making risky practice observable and moreover, multiplying the putative risky conduct on the part of people with HIV. Race's argument creates a vision of people with HIV scrutinised according to their HIV status, but then also surveilled and differentiated through medical technologies used in the post-crisis era in clinical care. Race argues that post-crisis methods of treatment help constitute methods of revealing unacceptable risky sexual practice, something that suggests a moral application of aspects of HIV treatment.

These perspectives on the regulatory properties of treatment and related medical technologies imply that reflexive treatment is also a matter of a moral self. There is therefore another point of connection with contest over the correct and responsible action of gay men with HIV discussed in the previous section. Foucault held that self-subjection and medicine were closely entwined. In medical self-subjection: "... one must become a doctor of oneself" in a system of "... permanent medical care", an orientation that resonates with his notion of the 'narrative of illness' mentioned in chapter two (Foucault, 1988: 31). This positive production of the self is not just a matter of survival, but is oriented to a "... certain complete achievement of life" (Foucault, 1988: 31). Thus, the positive production of self mobilises ethical self-contemplation:

One must know of what the soul consists. The soul cannot know itself except by looking at itself in a similar element, a mirror. Thus, it must contemplate the divine element. In this divine contemplation, the soul will be able to discover rules to serve as a basis for just behaviour and political action (Foucault, 1988: 25).

It seems possible to suggest that ethical self-contemplation resonates with both post-crisis treatment innovations in self-subjection and the imperative of altruistic conduct in matters of HIV prevention. Reflexive treatment, in this view, becomes a matter of the ethical construction of self.

Summary

This chapter has taken forward the idea of the reflexive use of HIV treatment to make it more relevant for gay men with HIV. In particular, reflexivity about treatment-related risk on the part of gay men articulates with a sometimes heated contest over responsible action. This contest is seen in the expectation of altruistic conduct and its corollary,

transgressive barebacking. And this contest about sexual practice is part of larger one concerned with setting the terms for the governance of the HIV epidemic. I elaborated on this idea of contest by considering perspectives from the treatment advocacy literature, critiques of psychologistic accounts of risk reflexivity, and the expanding duality of the innovations and imperatives attached to HIV treatment. These perspectives suggest that the effective government of the HIV epidemic has necessarily required the active involvement of people with HIV, including gay men. Treatment in particular, is made in the reflexive practices of people with HIV, implying that the post-crisis situation is achieved through them. As a consequence, the conduct of people with HIV is contested. For gay men with HIV, this contest is intricately bound up with their identities as responsible actors, creating a focus on their use of treatment and its imbrication with the risk of HIV transmission in sex. This idea of reflexive treatment articulated with contest over conduct, provides the basis for focusing on how gay men with HIV take on the interlocking discipline of treating and preventing HIV.

CHAPTER FOUR: METHODOLOGY

Introduction

The previous two chapters have been applied to establishing a critical framework of ‘reflexive treatment’ as a way of helping to conceptualise risk management in the post-crisis situation. This chapter explains how I researched aspects of the personal experience accounts of gay men with HIV with reference to reflexivity and post-crisis. In the first part of the chapter, I summarise my research focus. Next, the chapter considers my choice of qualitative method and draws together the methodological perspectives and assumptions that have informed my research practice. The last section describes the background and the procedures of the research. This separation of epistemology and research technique has been done to assist the reader. But I acknowledge that in practice, epistemology, ethics and procedure are woven together. To support the discussion of the methodology, this chapter also begins to introduce quotations from the interviews.

Researching post-crisis: aims and problematics

The previous chapters have raised several reasons for researching the post-crisis situation. I noted that how we understand the post-crisis situation for gay men with HIV lacks personal experience accounts of lived experience, a major justification for research on the topic. This gap is acute because the sexual practice of gay men with HIV and their use of treatment are in question in post-crisis discourse about the management of the epidemic. But in addition, personal accounts are required to critique the epistemological limitations of the dominant, treatment-optimism paradigm and its insufficient and ambivalent explanations of the effects of treatment on risk behaviour. I also argued that while there is a tradition of risk reflexivity research that is an advance

on treatment optimism style research, it requires development for gay men with HIV. for example, in connection with contest over responsible conduct. Therefore this research has two aims:

- addressing a gap in existing knowledge about how gay men with HIV themselves account for the post-crisis situation, with particular reference to HIV prevention;
- and advancing theory about how treatment effects and knowledge are taken into the HIV prevention practice of gay men with HIV.

These aims can be addressed through three ‘problematics’ derived from the previous discussion of risk governance in post-crisis: the meanings of treating and preventing HIV in the post-crisis situation; the mingling of innovation and imperative in the relationship between treatment and prevention; and responses to uncertainty and contestable knowledge connected with HIV treatment and implicated in prevention.

Meanings

The first problematic concerns describing how gay men with HIV account for living with HIV treatment in the post-crisis situation. As discussed in chapter two, there is not much research about how gay men with HIV construct life with effective HIV treatment and with reference to sexual practice. This lack is consistent with a claim about the general absence of discursively oriented research about lived experience in the area of HIV (Giami & Dowsett, 1996; Haour-Knipe & Aggleton, 1998). Moreover, treatment experience and sexual practice are typically researched separately in the area of HIV, although their combination is implied in post-crisis ideas like the link between treatment optimism and risky behaviour. In addition, research about risk practice in post-crisis has so far made few connections with risk society perspectives such as manufactured

uncertainty, ontological security and the contestable qualities of risk knowledge. Moreover the field is ambivalent about how treatment impacts on sexual risk practice and notions like treatment optimism or risk compensation have conceptual and explanatory limitations. These shortcomings are traceable into the idea of a linear determination of the effects of HIV treatment and risk practice, a perspective that can be critiqued through narrative research about post-crisis and theoretical and empirical accounts of risk reflexivity. There is ample scope and justification for developing a depiction of the connections between HIV treatment and risk management in sexual practice derived from the meanings and constructs of the personal experience accounts of gay men with HIV.

Identities

The second problematic for this thesis concerns identity and the joining of the technical and regulatory developments of the post-crisis situation. Effective treatment creates the prospect of a mutable HIV with related innovations for both self-care and HIV prevention in sexual practice. And the post-crisis focus on altruism and the responsible sexual conduct of gay men with HIV suggests the imperatives of HIV prevention attached to serostatus. However, the mixing of these innovations and imperatives need to be considered to advance reflexive perspectives on treating and preventing HIV in post-crisis. The perspectives developed in chapter three in particular, made note of power, the aesthetic dimensions of self-construction and the expanding duality of the risk management and disciplinary potentials of medical technologies such as the blood tests that are used to manage HIV treatment. Through the idea of risk reflexivity, and by drawing on accounts of treatment and prevention, I want to consider how gay men with HIV construct themselves in connection with the combination of the innovations and imperatives of the post-crisis situation. I want to make note of convergence and

contradiction in the rationalities of treating and preventing HIV and implications for self-understanding. Also, I want to address how these self-understandings are connected with accounts of risk management in sexual practice.

Contest

The third problematic for this research concerns the risk society notions of uncertainty and contest in treatment-related knowledge. Various aspects of HIV treatment have implications for HIV transmission risk. In particular, reinfection with drug-resistant forms of HIV and infectiousness connected with changes in viral load are relevant to gay men with HIV and have been implicated in the ongoing management of the HIV epidemic. As such, reinfection and infectiousness are suggestive of the manufactured aspects of risk in the post-crisis situation. Moreover, reinfection and infectiousness are open to technical uncertainties and are both a source of debate and dissent, particularly in connection with the imperative of HIV prevention, furthering this resonance with the perspective of risk society.

Qualitative interview method: perspectives and assumptions

The problematics for this thesis each imply an interest in how gay men with HIV account for their experiences of living with HIV treatment and preventing HIV. Qualitative interviews provide a way of exploring post-crisis meanings, identities, and engagements with risk knowledge connected with HIV medical technologies. In this section, I will justify my use of qualitative interview method in light of the various perspectives and assumptions I have found valuable for doing research with gay men with HIV about their experiences of HIV treatment and managing risk in sexual encounters. And because the research addresses issues such as ontological security and responsibilities in HIV prevention, I also point out some methodological issues to do

with using qualitative interviews. The following explores several traditions of qualitative methodology and identifies how in combination they help to provide critical perspectives on the generation of knowledge about the lived experience of gay men with HIV in the post-crisis situation. I will refer to the idea of the active interview, which I found useful because it draws attention to the social and relational aspects of the interview practice. In addition, I will suggest that my method was reflexive with some of the methodological features of inquiry about gay men's experiences with treatment, sexual practice and HIV transmission risk. These comprise the epistemological and ethical issues that arise in research about 'sensitive' topics and the articulation of power through medical meanings and identities in the HIV risk interview. I will also discuss how I addressed some potential limitations of the qualitative interview method.

Illumination, narrative, discourse

There are several 'traditions' of qualitative research that have informed my research: illumination; narrative; and discourse. I have relied on the idea that qualitative accounts can be used to illuminate lived experience. But I have also acknowledged that both narrative and discourse provide critical perspectives on the social practice of accounting for lived experience and the social construction of meaning and identity. Narrative also has some special resonance for the present research topic because it facilitates an engagement with the temporal aspects of accounting for illness and has also been applied to research about the construction of sexual identity. The following draws attention to the salient aspects of each of these traditions.

Illumination is one of the main justifications for qualitative inquiry about lived experience in general. The present thesis also subscribes to this idea, by seeking to illuminate aspects of the lived experience of gay men with HIV in the post-crisis

situation. In the area of health and illness, analysts hold that one particular virtue of qualitative inquiry is that it is a way to "... illuminate the subjective meaning, actions and context of those being researched" (Popay & Williams, 1997: 36). Following this view, qualitative method, particularly interviews, can help describe, in the language and meanings of interviewees, how they experience HIV treatment and its implications for sexual practice. This is a useful perspective as it suggests that interviews can create knowledge about personal experiences and therefore provide a counterpoint to dominant, medicalised perspectives on post-crisis risk. The illuminatory justification has wide carriage in the area of HIV. Illumination has been the orientation of most of the qualitative interview research conducted with long-term survivors before the advent of treatable HIV. In chapter two, I discussed the qualitative research about 'turnaround' conducted as effective treatment was introduced. This turnaround research relies on the notion that doing qualitative research helps to illuminate lived experience and therefore can help us to understand the social aspects of the advent of treatable HIV.

However, an uncritical use of the illuminatory rationale of qualitative interview research can create a sense that personal accounts somehow provide unmediated access to experience (Bury, 2001). Conversely, the narrative orientation to qualitative research provides the basis for a critical engagement with the epistemological status of the personal experience account. Researchers have analysed personal accounts of living with HIV as stories about events in the life course and therefore relied on a sense of accounts as social constructions (Roth & Nelson, 1997). For Bury, personal experience accounts reflect the agency of subjects as they act to construct their personal biographies and identities (2001). He therefore maintains that accounts do not provide unmediated access to lived experience. With reference to sex and sexualities, Plummer has written about the epistemological status of personal experience accounts. For instance: "...

sexual stories must be seen to be socially produced in social contexts by embodied concrete people experiencing the thoughts and feelings of everyday life” (Plummer, 1995: 16). In this view, interview accounts or narratives are seen as “... social actions embedded in social worlds” (Plummer, 1995: 17). These story-making perspectives about personal accounts suggest that accounts of lived experience are constructed by social actors interested in achieving narrative effects. This narrative perspective suggests that personal experience accounts can be used in a critical way to explore the reflexive construction of the post-crisis experience.

Another attraction of the narrative perspective is that it also affords multiple accounts of experience. The idea of more than one story about lived experience opens up qualitative interview research to the post-structural notions of the “... fragmented subject” (Fox, 1993: 19) or the fragmentation of stories (Plummer, 1996). In this view, along with a critical illumination of lived experience, the discontinuities and multiplicity of stories can be an important focus for research (Ezzy, 2000). This thesis seeks in part to problematise orthodox constructions of post-crisis. Narrative analysis suggests that qualitative interviews can provide a basis for exploring the other accounts and explanations of living in the post-crisis situation.

Narrative analysis also has another, ‘double’ relevance for this thesis because it has been applied to both the lived experience of illness and in the area of sex and sexuality. Narrative implies reflexivity, ontology and time, features of analysis that resonate with reflexive biography in the post-crisis situation, manufactured uncertainty and the historical advent of treatable HIV (Hyden, 1997). In medical sociology, illness is understood as a form of ‘biographical disruption’ or experiential rupture of narrative, implicating changes in identity and methods of coping with threats to self (Bury, 1997;

Bury, 2001). Illness narrative can also have a constitutive function of: "... conveying, expressing or formulating our experience of illness and suffering" (Hyden, 1997: 64). Illness narratives are also taken to suggest reflexivity in relation to the future (Good, 1996). In this respect, the temporal order in narrative, or "emplotment", has an important ontological function for the narrator (Good, 1996: 144). As suggested in the previous chapters, HIV treatment creates questions of ontological security in the life course, creating a specific relevance for a narrative perspective in research about the post-crisis experience. Sexual story-making is also a well developed research field, although less obvious in the area of HIV where behavioural research predominates. Plummer has elaborated thinking about narrative in connection with sex and sexualities, or what he calls: "... personal experience narratives around the intimate" (1995: 7). This approach traces points of continuity between life as a story, stories about life and science as a narrative product, a perspective that implicates the entire research process in narrative analysis. Plummer has also pointed out that narrative draws attention to the social practice of telling a story and constructing identity (Plummer, 1996). Narrative analysis therefore also implies going beyond the content of the story to think about how stories are made, including features of narrative such as who tells them and in what circumstances. An important perspective is that some stories about life are not told perhaps because for some reason they are not legitimised. Analytical focus can then be applied to "... why specific stories have their specific times, whilst others do not" (Plummer, 1996: 38). This view on the social conditions of story-telling is valuable for qualitative interview research about the lived experience of post-crisis. It opens to view the interplay of the social circumstances of story-telling and the interests of story-tellers, providing another way of addressing reflexivity and the advent of treatable HIV. It also raises the question why it is that so little qualitative research has been done about how gay men with HIV themselves encounter HIV prevention in the post-crisis situation.

By extension, the notion of discourse has also been a useful perspective in my research about post-crisis. Qualitative interviews can be used to help problematise discourse or the rules of knowledge-making about HIV treatment and prevention. By looking ‘above the sentence’ to consider the rules that govern the practices of accounting for experience, the social value of certain forms of knowledge can become intelligible. Post-crisis in particular is constituted through assumptions and contests about the effects of treatment in lived experience and risk management practice. Discourse oriented research can help problematise how people engage with the contestable assumptions of the post-crisis order, as a matter of submission, re-configuration or resistance. Discourse can be defined as the knowledge-making: “... practices which systematically form the objects of which they speak” (Cameron, 2001: 15). In another definition, discourse: “... constitutes the objects of knowledge, social subjects and forms of ‘self’, social relationships, and conceptual frameworks” (Fairclough, 1992: 39). Informed by these perspectives, research can be applied to the exploration of the: “... systems of rules which make it possible for certain statements but not others to occur at particular times, places and institutional locations” (Fairclough, 1992: 40).

The active interview approach

The traditions of illumination, narrative and discourse therefore provide the basis for a critical engagement with personal accounts of the post-crisis experience. But they have less to say about how such accounts can be achieved. Therefore I also want to make reference to the idea of the active interview approach to generating personal experience accounts (Gubrium & Holstein, 2002; Holstein & Gubrium, 1997).

The key attraction of the active interview method is that it focuses on the interview as a

social performance. It draws attention to how all the interview participants contribute to the project of generating accounts of lived experience. The active interview approach therefore fits with the assumption that post-crisis experiences can be explored in a critical way using qualitative interviews. In that regard the active interview approach implies a rich tradition of critical engagement with the creation of accounts of lived experience. Some examples are the notion of "... dramatic realisation" in social experience (Goffman, 1959: 40), and the perspectives of 'interview society' (Atkinson & Silverman, 1997) or 'cinematic society' (Denzin, 2002). The qualitative interview can also be theorised as a form of conversation (Kvale, 1996); as an instance of story-making (Plummer, 1995); and as an activated performance (Gubrium & Holstein, 2002). In general, these perspectives suppose that we live in a society where the interview is a social form that has a particular use. The interview is used to reveal experience and through it, lived experience is opened to illumination and therefore public scrutiny of some kind. The interview is generated by the social interaction of the interviewee and interviewer, both of whom rely on shared knowledge about how to practise the interview. The interview also requires and produces certain sorts of subjects, both imaginary and embodied, such as the interviewee, interviewer and a notional audience (Plummer, 1995). People are therefore reflexive with the social purpose of the interview situation. For example, they have experiences and expectations about the roles they are to perform, the stories that can be told and how and by whom their accounts will be received. In the interview experience, the depictions of lived experience are assembled and edited for social purposes and in that sense express the aesthetic intentions of the interviewee and the interviewer (Atkinson & Silverman, 1997).

The active interview approach also implies that the interviewer is engaged with generating data. Based on this notion of the active interview, my role as interviewer was

to mobilise: “... narrative production” (Holstein & Gubrium, 1997: p 123) and to “... activate the respondent’s stock of knowledge and bring it to bear on the discussion at hand in ways that are appropriate to the research agenda” (Holstein & Gubrium, 1997: 123). In the active interview approach, the interviewer may suggest “... possible horizons of meaning and narrative linkages that coalesce into emerging responses” (Holstein & Gubrium, 1997: 125). Through this activity on the part of the interviewer, the qualitative interview then becomes a way of documenting “... interpretive practice” (Holstein & Gubrium, 1997: 125). In this approach the researcher and the researched interact as they explore the topics at hand, moving between describing, interpreting and theorising as a matter of ‘inter views’ (Kvale, 1996). The active interview approach therefore implies that the qualitative interview is itself part of the general social practice of constructing meaningful accounts of the post-crisis experiences of gay men with HIV. It also implies that along with recognising the meaning-making achievements of the interview participants, effective interviewing requires a reflexive interviewer.

Interviewing about ‘sensitive’ topics

The notion of ‘sensitive’ topics has special relevance for the present topic, because it brings together ethical and epistemological implications (Coyle, 1996; Lather, 1995). For example, there are several sensitive qualities to researching the post-crisis experience of gay men with HIV. Risky sex may well have been how the interviewee came to be infected with HIV, so questions on that topic may be uncomfortable. Asking interviewees to reflect on issues such as reinfection may create fears about future health. Questions about risky sex also imply the responsibilities of the person with HIV in terms of preventing HIV transmission to sexual partners and perhaps in relation to the effectiveness of treatment and health prospects.

Sensitive topics also raise concerns about what the qualitative HIV risk interview achieves in terms of epistemology. Analysts have written about the shaming inherent in research that investigates proscribed risk behaviours in the area of HIV. Drawing on Foucault's notions of confession, self-knowledge and 'truth games', Bourgois has discussed the 'symbolic violence' of research that asks people about their risky drug-using practice such as sharing needles and syringes (1999). Research questions can put the interviewee in the position of having to account for and justify what they have been doing. Research questions, often derived from the public health imperative of rational disease control (and in the US at least, out of drug control policies based on abstinence), are figured around why people do not reduce risky behaviours. This orientation makes visible the discrepancy between what the individual has been doing and risk reduction advice, suggesting the public health interest in regulation and compliance mentioned in chapter two (Armstrong, 1995). Such questions may also fail to encounter the situatedness of risk management in the drug use lifestyle, and therefore represent the drug user as irrational and problematic. Bourgois suggests that researchers need to be aware of the epistemological assumptions and 'iatrogenic' effects of research figured around the requirement to confess risky behaviour.

But there is some unevenness in the theoretical work about interviewing and 'truth games'. For example, theorists differ about whether the qualitative interview is a technology of confession or examination. Fairclough, also with reference to Foucault, has described the research interview as a form of self-examination through a contrast with counselling as confession:

Interview and counselling represent respectively objectifying and subjectifying genres corresponding to the objectifying technique of examination and the subjectifying technique of confession, and the modes of discourse which

bureaucratically 'handle' people like objects on the one hand, and modes of discourse which explore and give voice to the self, appear to be two foci of the modern order of discourse (Fairclough, 1992: 54).

This depiction draws attention to the different sorts of disciplines and engagements with self that become visible in qualitative interviewing and counselling. However, this depiction may be idealised in the sense that it precludes the mixing of objectification and subjectification or the blending of examination and confession. Fairclough seems to regard the interview as a mode of examination in contradistinction with counselling as confessional. However, Atkinson and Silverman discuss the epistemological status of the qualitative interview in terms of confession (Atkinson & Silverman, 1997: see pages 305 and 309), but also as a mixture of "... examinations and confessions" (Atkinson & Silverman, 1997: 314). In light of the unevenness in the theoretical work, perhaps the qualitative interview about sensitive topics can be seen as a way of combining examination and confession. Moreover, the disciplinary qualities of the interview implied by the idea of sensitive topics may have much to do with the public health orientation to risky behaviour, as discussed by Bourgois (1999). It is possible that the interview procedure can facilitate the superimposition of the observing gaze (the question about risky behaviour) and the self-gaze (self-reflection on the import of risk behaviour). For the present research topic, the focus on risk behaviour on the part of the interviewees can be thought of as a particular form of self-discipline brought about by confession and examination intersecting with the sensitive qualities of the research topic, which are in part to do with the post-crisis concerns about risky sexual practice among gay men with HIV. The disciplinary qualities of the sensitive topics of qualitative interviews about post-crisis also suggest how interviews about HIV risk have the effect of mingling epistemology and ethics in the practice of research.

Another feature of the HIV risk interview that also implies both ethics and epistemology, is the involvement of aspects of HIV treatment and related medical technologies in the construction of identity, speaking position and authorial voice. Interviewing people with HIV about HIV risk implies the use of medical technology to construct relationships in the interview and therefore also implies the articulation of power. It is important to address some aspects of medical power in the interview for the purpose of achieving a reflexive research practice.

It is not easy to address issues of power in research. Research about the health status of marginal groups requires engagement with them, but can lead to the production of knowledge that reinforces social marginality (Briggs, 2002). Such objectification may mean that a kind of determinacy is built into research at the level of the constitution of identity, which may lead to an ethical concern over the (mis)representation of lived experience (Fontana & Frey, 1998). In relation to HIV, approaching people on the basis of their diagnosed infection contributes to the construction of knowledge about a 'social object' of the person with HIV and may over-construct the importance of HIV identity for the interviewees. For Briggs, a way through these dilemmas of representation and power is available in forms of critical discourse analysis applied to the social relations of research (2002). In this kind of analysis, the problematics of the identity and speaking position of the researcher come into focus as a matter of reflexive research practice (Ramazanoglu & Holland, 2002). However, as discussed in chapter three, Adkins has suggested that reflexive methodologies can actually work to reinstate power in research relationships (Adkins, 2002). Through the idea that reflexivity frees agency from structure, reflexive methods actually work to privilege the 'mobility' of the reflexive

researcher. It seems difficult to sidestep this interplay of medical technology and power in qualitative interview research.

Only a few researchers have written in a reflexive way about doing qualitative research with people with HIV with reference to questions of identity and authorial legitimacy (Coyle, 1996; Lather, 1995). The concerns here centre on legitimacy as a spokesperson on behalf of people with HIV and validity in relation to the depiction of the HIV experience. In research about the HIV experience, a binary can form around the HIV positive/negative distinction that constructs a kind of epistemological othering where the HIV negative researcher is an outsider and the HIV positive researcher is an insider. This epistemological othering mobilises a question over the legitimacy of the outsider view. Researchers have tried to deal with these concerns by declaring their otherness and being open about their knowledge of their own HIV serostatus (or lack thereof), or basing a dialogue on shared experience that does not have to do with HIV, such as sexual identity or gender (Coyle, 1996).

Lather has specifically explored the constitutive effects of power in the representation of the HIV experience. Lather has written of a: "... search for a multiply layered way of telling stories that are not mine" (Lather, 1995: 53), and focusing on a researcher role as 'translator'. In this perspective, Lather also refers to the notion of "... not knowing" in the creation of a research text (Felman and Laub, (1992) cited in Lather, 1995: 49). Instead of a research text as a kind of total knowledge, Lather creates scope for "... a multivalent text ... that signals tentativeness and partiality" (Lather, 1995: 53). Lather also makes an epistemological argument: "... against both extreme forms of social constructionism and any claim to unmediated access to some real" (Lather, 1995: 54). Lather advocates research that can address the binary of HIV positive/negative

through an exploration of continuums of risk that embrace all subjects, including the researched/researcher and HIV positive/negative (Lather, 1995: 61). Another technique used by Lather is to involve people with HIV in the interpretation of data and to produce multi-authored research texts. Coyle's and Lather's propositions do not entirely neutralise the issue of the authorship of depictions of lived HIV experience. However, Lather's perspectives are useful in that they invite an engagement with depictions that are provisional and incomplete and in that sense are reflexive with subjectivity and power.

Lather also makes the point that the divisibility of identity brought about by the identification of HIV serostatus is deeply inscribed in risk management (1995). As discussed in chapter two, the HIV antibody blood test (a form of medical technology), distributes identities in relation to the risk of HIV transmission. HIV positive means that you are already infected and capable of transmitting the virus: HIV negative means that you may be at risk of infection. In this sense, risk is 'made' in the difference between HIV positive and HIV negative. This difference in risk identity means that the position of the researched in the interview is imbricated with the risk-defining qualities of medical technology, itself a theme of this study about the advent of treatable HIV and sexual practice. Medical technology is already in the interview and the interview is already inside medical technology. Moreover, it is not possible to address interview questions about lived experience to the person with HIV without these uses of medical technology. In this view, the risk constituting effects of medical technology help, and are required, to construct social relations in the HIV risk interview, bringing the medical construction of risk identity into knowledge production or epistemology. The HIV experience is not so much influenced by medicine as depicted according to its epistemological assumptions.

In my research, I therefore acknowledge these concerns about medical technology, authorial voice and identity, precisely because the HIV treatment experience is central. Following Lather in particular, I assume that the research account is partial in an experiential sense, but I also recognise how it is configured through the epistemological properties of HIV medical technology and its capacities to confer sero-identity (1995). From this point of view, the research account can reflect on how HIV medicine helps construct subject positions inside the research experience. From this perspective research can problematise totalised depictions of the HIV experience or serostatus identity. For example, this perspective opens up to view how aspects of HIV positive serostatus may be seen as a medico-cultural product, raising questions over the reductions and determinations that come to be attached to forms of risk identification such as 'HIV positive'. It is also important to recognise that research about the constitutive effects of medicine is already constituted inside medicine. This is a situation of a kind of legitimate reflexive anxiety, a vigilance figured around questions of authorship and the depiction of lived experience, an orientation that I think is altogether appropriate.

Addressing some limitations of the qualitative interview

It is also the case that in general, qualitative interview research methods have some limitations. The 'interview society' perspective suggests that the practice of the research interview can be open to an "... uncritical, neo-Romantic celebration of the speaking subject" (Atkinson & Silverman, 1997: 305). Research accounts predicated on the idea of illumination may 'clean up' accounts in an effort to further a conception of the interview participants as rational, articulate citizens (Alldred & Gillies, 2002). It can also be said that the qualitative interview method is individualistic, cognitive,

disembodied and not ‘naturally occurring’ (Kvale, 1996). The interview method is also time efficient compared with other methods such as ethnography, which means that it lends itself to use in busy organisational settings. Expedient use of interviews may limit knowledge-making and methodological innovation, particularly in the case of one-off interviews (Oakley, 1981). Each of these critiques raise questions about the validity of interview-based accounts of the lived experience of treating and preventing HIV.

However, there are ways of addressing the limitations and promoting the validity of qualitative interview research. Qualitative interviewing can be done with an awareness of the cultural context of ‘interview’ or ‘cinematic’ society and how accounts of lived experience are actively produced by social actors. Moreover, it is through this sense of conjoined improvisation figured around the concerns of the research that the interview comes to occupy a “... privileged position” in knowledge-making (Kvale, 1996: 285). In this sense, the qualitative interview has an interpretive justification:

... social reality is regarded as the product of processes by which social actors together negotiate the meanings for actions and situations; it is a complex of socially constructed meanings ... social reality is not some ‘thing’ that can be interpreted in different ways; it is those interpretations (Blaikie, 1993: 96).

Similarly, qualitative interviews can be based on the idea that: “... talk is social action: people achieve identities, realities, social order and social relationships through talk” (Baker, 1997: 132). The qualitative interview is therefore an exemplary way of exploring the meaning-making achievements of social actors. Defined in this way, the qualitative interview is also consistent with structuration theory, which proposes that the actions of knowledgeable subjects, reflect and produce social realities (Giddens, 1984). Valid qualitative interview research therefore arises in the depiction and

problematization of lived experience, rendered so that is intelligible and justifiable with reference to its 'knowledge community' (Seale, 1999). Qualitative interviews with gay men with HIV may not be definitive in the sense of constructing a kind of totalised knowledge about the post-crisis experience. They remain however, one key method for constructing meaningful accounts of the personal experiences of gay men with HIV living in the post-crisis situation.

The re-interview research design

The previous section has outlined my assumptions about qualitative interview research about how gay men with HIV construct their experiences of treating and preventing HIV. This section outlines the conduct and analysis of the qualitative interviews used in this thesis. In the first few parts of this section, I will provide a background and rationale for the qualitative re-interview research design. I will also identify some of the distinctive aspects of the research, including its clinical setting and some of the experiential influences on my work. In the last few parts of this section I will describe the sampling strategies I used, some of the salient social and treatment characteristics of the volunteers, the style and content of the interviews, the ethical arrangements for the study and the approach to the analysis. I also identify and reflect on how I addressed bias and promoted the quality of this research.

Background

In 1999 and 2000 I was employed for 18 months, (full-time for nine months, part-time for nine months), as a contract researcher at a London HIV treatment clinic to work on an epidemiological study. Drawing on the treatment-optimism paradigm, the study examined the effects of treatment and treatment perceptions on the sexual risk behaviour of gay men with HIV (Stephenson et al., 2003). The study was funded by the UK

Medical Research Council (MRC) and used both quantitative and qualitative methods. The principal investigators comprised senior staff from the clinic and the MRC (a medical epidemiologist, a HIV clinician, a clinical psychologist and two HIV public health specialists). The study aimed to describe the impact of treatment on the risk of HIV transmission and to identify behavioural and clinical variables that could become baseline measures in a future controlled-trial for a risk behaviour intervention. Exploratory research such as this is sometimes called a 'phase one trial' or 'modelling phase' in the parlance of controlled-trial method (Medical-Research-Council, 2000). A quantitative survey was designed to measure risk behaviour and its associations with treatment experiences and perceptions and some related variables such as depression and physical functioning. The qualitative aspect of the study was included to address an MRC policy recommendation that controlled-trials have a formative period in part focused on identifying the "... active ingredients" and assessing the social acceptability of the proposed intervention (Medical-Research-Council, 2000: 9). The qualitative aspects of the study included interviews and focus groups. These forms of data generation were designed to help orient the epidemiological research and help plan the intervention trial by describing the social aspects of the risk behaviours and perceptions of the putative intervention group.

I was employed to help design the behavioural questionnaire, format it for computer assisted self-administration, recruit participants and assist them to self-administer the questionnaire. I also organised the collection of other data including blood, throat swabs and urine for testing for sexually transmitted infections. I was responsible for data management prior to analysis. The quantitative component was the most time-consuming aspect of the study. I recruited 422 men over 12 months, a process that involved almost constant presence in the HIV treatment clinic.

I was also responsible for the qualitative component of the study. My previous experience with qualitative interview research was one of the reasons I was employed by the MRC team (Connell et al., 2000; Davis, 2002; Davis et al., 1991; Dowsett et al., 1992a; Dowsett et al., 1992b; Sharp et al., 1991). With feedback from members of the MRC research team, I designed and managed the qualitative interview research. For example, I created topic guides, recruited interviewees, conducted interviews, analysed the data and prepared articles for publication. Between March 1999 and March 2000, I conducted 25 qualitative interviews with volunteers from the clinic. To help orient the design of the questions for the epidemiological questionnaire and to establish the qualitative research, I decided to do eight qualitative interviews in the early stages of the project. The remaining 17 interviewees were drawn from the epidemiological survey sample once that data collection had commenced. These 25 interviews were made available for my doctoral studies in 2000, partly in recognition that I among the research group was most able to analyse them. Qualitative and quantitative research findings have been reported in the literature and at conferences (Davis et al., 2000; Davis et al., 2001; Davis et al., 2002; Stephenson et al., 2003).

The re-interview rationale

In 2000, I conducted a literature review for the Terrence Higgins Trust to assist them to develop HIV prevention strategy with people living with HIV (Summerside & Davis, 2001; Summerside & Davis, 2002). I had also been analysing and reflecting on the 25 interviews done for the MRC study. The experience of digesting research for educators and reflecting on the interviews led me to consider the direction of my doctoral research. In mid 2000, I decided that it would be useful to talk to the interviewees a second time.

The 25 interviewees were contacted and 11 re-interviews were conducted between August and October 2000.

I decided to re-interview the men for several reasons. I wanted to explore the risk society idea of manufactured uncertainty. I also wanted to consider the viability of the concept of treatment optimism in connection with sexual practice. And, in general, I wanted to move the research into an exploration of risk reflexivity and post-crisis risk governance. It had become apparent in the interviews and on reflection that the interviewees wanted to discuss features of their experience of treatment that exceeded the scope and purpose of the MRC research. Thematic analysis of the first interviews also pointed to the centrality of concerns about uncertainty and security. These concerns included uncertainty related to treatment itself or less obvious (but ultimately crucial) connections with love relationships and financial security. The re-interview method had the benefit of defining a period of treating and monitoring HIV infection that could be a focus for discussion and reflection. Re-interviews also became important because treatment optimism did not seem to have the form or implications for sexual practice suggested by prior quantitative research. It seemed in interviews that treatment optimism did not have a straightforward link with risky sexual practice, a perspective that was borne out in later quantitative analyses in the MRC and other studies (Elford et al., 2002; Stephenson et al., 2003). The idea of treatment optimism reinforces a general idea of medical watershed and post-crisis as an undifferentiated epoch of manageable disease. This idea of treatment optimism did not seem to fit with the uncertainties and insecurities of post-crisis expressed in interviews. These conceptual problems warranted further exploration. I also wanted to address the experience of gay men with HIV in connection with the regulatory qualities of HIV prevention.

The re-interview approach is therefore a feature of the research design. Such an approach introduced an iterative dimension to the production of data, a method that has been said to enhance qualitative research (Oakley, 1981). I use iteration to mean re-engaging with the interviewees and asking more questions, but also in terms of reflecting on the interview texts themselves (Gubrium & Holstein, 2002: see page 29). The re-interview method allowed me to review, modify and elaborate my interpretations and incorporate theoretical perspectives into the research. Re-interviewing also represented an important direction for the research. For example, I could have tried to interview another group of gay men, such as long-term survivors or men diagnosed after the advent of effective HIV treatment. But I made a decision that re-interviewing and the possibility of joint reflection on aspects of post-crisis experiences would enhance the development of my emerging thesis, particularly in connection with living with some of the manufactured uncertainties of HIV medicine. These choices also meant that the method moved towards joint interpretive practice, building a depiction of lived experience through repeated interaction with the interviewees. In this view, the re-interview method could be taken to be a form of 'respondent validation' (Mays & Pope, 2000; Seale, 1999). This is because, in the re-interviews, I was able to ask questions about my interpretations in a way that helped to verify or problematise them.

Sampling

The interviewees were volunteers from the London HIV treatment clinic, most of whom had completed the epidemiological questionnaire. As I have discussed, to begin the qualitative research and orient the quantitative research, I approached eight men in the clinic and invited them to do an interview. But once the epidemiological survey had started, another seventeen men were invited to participate in both the questionnaire and the interview. These volunteers were recruited by the nurses and doctors providing care

in the HIV treatment clinic. The nurses and doctors then introduced the volunteers to me when I asked them to do the questionnaire and also invited them to do a qualitative interview. It was decided to not approach people 'cold' in the clinic because this practice had proved awkward in the public space of the waiting room and problematic in terms of identifying homosexually-active men by appearance. It was also a tradition of the clinic to recruit participants for clinical trials via their health carers, who were in a position to decide whether they matched selection criteria for medical research. However, in terms of social research, this recruitment practice had the effect of gate-keeping, raising questions over access, volition and informed consent, and perhaps contributing to a situation where patients were 'volunteered' in one way or another into the research (Miller & Bell, 2002).

In general, the patients were willing to participate in the study. One man declined a qualitative interview with me. I believe that so few people declined because the decision to participate in the research project overall was negotiated between the patient and their health carer. If I was introduced to them, they had already decided to participate in the study, including the qualitative interview.

The qualitative sample was designed to complement the questionnaire sample in terms of describing the clinic population of gay men. Therefore, the interviewees were selected according to purposive criteria. These criteria comprised: a spread of ages; volunteers in and not in regular sexual partnerships; differing years of diagnosis, especially before and after the introduction of effective HIV treatment in 1996; and volunteers currently using and not using treatment. I stopped interviewing once I believed that I was not gaining much additional information from further interviews. The sample was mostly white and middle-class, which reflected the characteristics of

gay men surveyed in the clinic (Stephenson et al., 2003) and gay male samples in national surveys of people with HIV (Weatherburn et al., 2002). Most of the interviewees were diagnosed in the 1990s, more than half were currently using treatment. Most of those using treatment had been doing so for less than 2 years (see Appendix One).

Because the re-interviews had not been negotiated with participants at the outset, a separate process was instituted where the men were invited to do another interview. Eleven men were re-contacted and consented to be interviewed by September 2000. The recruitment for re-interviews proved to be complicated. It was achieved in two main ways. Doctors and nurses were asked to hand invitations out to the interviewees when they returned to the clinic for consultations. I also spent time in the clinic and if I met an interviewee, I invited them to do another interview. Out of 25 original interviewees, six men were not contacted. One man had died. Two men were not approached. One had spoken of suicidal thoughts in his first interview and I chose not to recontact him. One had given a false name to me, suggesting he did not want to be approached again. I found that three men had not recently attended the clinic, suggesting they had gone elsewhere for treatment. Patient files made no note of the reasons for their absence. However, one man who had left the clinic for another, was traced by letter through his clinician. Therefore, fourteen men volunteered to be re-interviewed. However, three men either did not respond to my telephone calls or were unable to make a suitable time owing to other commitments. Compared to the group of 25 interviewees, the group of eleven was older and a larger proportion were currently taking treatment (see Appendix One). But as with the original group, different ages, relationship and treatment experiences were represented.

I addressed sampling bias in several ways. The qualitative sample was drawn from the survey sample on the basis of purposive criteria to help ensure that the depiction of the experience of post-crisis was relevant to most categories of gay men with HIV using the clinic. However, as I have mentioned, the quantitative and qualitative sampling relied on gatekeeping. Gatekeeping may have introduced bias in the sense that the sample was either self-selected or selected by the clinicians. There are no data about why some patients did not volunteer for the epidemiological survey. The MRC research team asserted that a third of the gay male clinic population was finally surveyed and that the sample was similar to national samples of gay men with HIV in terms of age, ethnicity, AIDS diagnosis and treatment experience (Stephenson et al., 2003). The survey sample was therefore held to be representative, improving confidence about the ability to generalise about all gay men attending the HIV clinic. However, in strict terms, there is some uncertainty about whether the surveyed men differ from the clinic population in unknown ways.

However, the re-interview method had the effect of revealing some possible sources of selection bias. Several men were unavailable for a re-interview because they had apparently moved out of the clinic or were excluded because of questions over their well-being. So it seemed that how people engaged with the clinic and HIV illness itself shaped who was asked and willing to do an interview. The sampling procedure may have selected men having successful treatment experiences or coming to the clinic on a regular basis. Both these aspects of the treatment experience suggested that the interview volunteers were more engaged with the clinic and therefore HIV treatment. In addition, interviewees who wanted to contribute to research may have selected themselves into the re-interview part of the research. This last rationale had support in

the interviews. Some interviewees reflected that they had done the interview for altruistic reasons: "... if those of us who've got the disease can help then we should" (Thomas: 2); "I don't mind. If it helps you with your study, fine, great" (George: 2). (All names are pseudonyms. The number following the name refers to the first (1) or second (2) interview). The interviewees seemed to find virtue in reciprocating for the care they received in the clinic by participating in the research, an orientation that mirrored other sorts of research participation in the clinic, such as clinical drug trials. Some of the interviewees reckoned that they "should" (Thomas: 2) participate. It may be that in the clinic setting, to volunteer for research is a good act, a practice of the virtuous citizen of the post-crisis HIV epidemic. It is noteworthy that altruism on the part of volunteers emerged as an aspect of the research method. As I have argued in chapter three, altruism is also an aspect of post-crisis responsibilities about HIV prevention. It seems that altruism has the property of unifying the use of medical services, HIV prevention and research participation. In a sense then, sample recruitment reflects the articulation of imperatives to do with the management of the HIV epidemic.

This research therefore faces some problems of self-selection bias possibly connected with satisfaction with the treatment experience in the clinic and altruism. But self-selection bias is a problem in any research (Robson, 1993). For example, the MRC study may have been subject to unknown forms of selection bias. It is also the case that in qualitative methodology, there is less interest in describing the characteristics of a population, and more attention to, for example, detail and variation in accounts of personal experience with a view to generating and questioning knowledge about such experience. This research therefore provides a specific depiction of how gay men with HIV of different ages and with different experiences of HIV treatment, spoke about their encounters with post-crisis risk, enhanced by the iterative and reflective qualities of the

re-interview method. But because of a possible general effect of required altruism in research participation and how it intersects with HIV illness and treatment, this depiction is possibly also a conservative one with regard to the depiction of the negative aspects of the post-crisis experience.

Doing the interviews

The original and subsequent re-interviews were conducted in consulting or counselling rooms in the HIV clinic. These rooms were chosen to avoid interruption, but they were also ‘sterile’ places fitted out with clinical equipment like sinks, rubber glove dispensers and examination tables. The use of these environments brought the qualitative interview into close proximity with the consulting or counselling experience. Interviewees reported that they had been in these rooms for counselling. One interviewee recalled that he had been diagnosed in the interview room: “I got my diagnosis here ... in this very room (Kevin: 2). It seemed that other HIV ‘examinations and confessions’ prefigured the qualitative interview in location and style. Perhaps a feature of the HIV treatment experience is the superimposition of the various forms of examination and confession.

I designed the topic guide for the first 25 interviews based on the aims and objectives of the MRC study and through negotiation and approval with the principal investigators. I also adjusted the topic guide as I did the interviews. I eventually dispensed with the guide once I had become familiar with it and had embarked on following up emerging themes. In the interviews, I asked the men to describe their experiences of HIV treatment, sexual behaviour and risk. I asked the men to outline their HIV story, which embraced diagnosis of HIV and AIDS, illness and treatment and related medical technologies such as viral load testing. I also aimed to gain a sense of the social settings of sexual practice, so I asked the men to describe how they socialised, their preferences

for finding sexual partners and about regular sexual partners. The men were asked to consider HIV risk in a particular way. I asked the men to talk about a sexual episode that had worried them in relation to HIV transmission. On the basis of this account, I asked more questions about approaches to safer sex, disclosure of serostatus to sexual partners and beliefs about reinfection and viral load. Unless these issues had already been broached, I asked similar questions about situations of anal sex without condoms, where relevant. The interviews generally finished with a discussion of the use of HIV treatment and support services, experience with sexually transmitted infections and treatment, and ideas for HIV risk interventions and any questions or comments. The interviews lasted between 60 and 90 minutes and were audio-taped for transcription.

The re-interviews occurred after (at least) 12 months of the first interview, were similar in style and used some of the same themes. But the re-interviews were also oriented to aspects of reflexivity in post-crisis, such as manufactured uncertainty and security, questions over the notion of medical watershed in lived experience, and the various responsibilities of gay men with HIV pertaining to HIV prevention. I had also become interested in agency and reflective research practice. I asked in general how life had been over the previous 12 months, which meant that the interview took on content that reflected recent lived experience. Discussions ranged from new relationships, pension arrangements, safer sex and treatment side-effects. In the re-interviews, I gave more emphasis to life expectations and the manufactured uncertainties of HIV medicine and encouraged detailed discussion about risk management in connection with reinfection and viral load. I also asked the men if they recalled the previous interview. In general, the interviewees reported that they did not. The quantitative survey was recalled instead, perhaps reflecting the novelty of the laptop computer used to administer the questionnaire. I also asked the interviewees to discuss a HIV prevention advertisement

introduced in the interview (see Appendix Two). This discussion was not an evaluation of the advertisement. The advertisement was introduced as a way of revisiting issues around sexual behaviour and risk and to help make a connection with public discourse about HIV prevention. The advertisement was called *Assume nothing* and appeared in various gay print media in the middle of 2000. It was therefore read by audiences of gay men who were HIV positive, negative and untested. The advertisement was part of an awareness building campaign that tried to get people to reflect on mistaken assumptions about the HIV status of their sexual partners. In the last part of the interview, I asked the men to reflect on their expectations of treatment and self-care strategies. I offered the interviewees pencil and paper if they wanted to make notes. Some men made jottings and these became a source for discussion. To explore the research process, I also discussed with the interviewees how they had found the interview experience. The re-interviews also lasted between 60 and 90 minutes and were audio-taped for transcription.

The re-interview method also marked a shift in my practice of interviewing connected with identity. I invited the men to be re-interviewed to explore themes that had emerged in previous interviews. But in methodological terms, the re-interviews also had the effect of altering the subject positions of the interviewer and the interviewee (Gubrium & Holstein, 2002; Ramazanoglu & Holland, 2002). In particular, when I invited the interviewees to do a re-interview, I informed them that it would be used for my doctoral research. This disclosure had the effect of re-defining our relationship. In the context of the MRC study, the interviewees were informants and I was something akin to a forensic risk investigator, collecting accounts of behaviour in an effort to describe the connections between treatment and sexual practice. In this arrangement, the research was defined by a HIV prevention imperative and relied on several identities such as the

assiduous social scientist and the altruistic patient. The interviewees were also constructed as gay men with HIV, as somehow representing the object of interest to behavioural epidemiology. I was a neutral and skilled observer. My own identity was less important, or somehow screened out by 'professional conduct'. However, in the context of the re-interviews, my identity as a student was put into the research (Oakley, 1981). This shift involved a partial dissolving of the medical-altruism imperative into a request for cooperation with the idea of my doctoral investigation. The re-interviews and the shift in the mode of inquiry allowed me to develop the research agenda, to re-theorise, verify and modify my interpretations. But the shift also disrupted the speaking positions of forensic researcher and its corollary, the gay man with HIV reflecting on risk behaviour. The shift also drew attention to different modes of authorial voice connected with the shift from researcher to student, suggesting the 'mobile' relations of reflexive subjects, with ramifications in ethics and epistemology.

Moreover, identity questions emerged in the part of the interviews where we reflected on the interview experience. At the end of interviews I typically asked interviewees if they had any questions for me. Mostly, interviewees asked about how the research would be used for the development of HIV prevention policy. But one interviewee asked me about my HIV serostatus:

MD: Is there something we've missed? Something we've not asked?

Andrew: Are you positive?

MD: No.

Andrew: Just came through (1).

Andrew's question suggested that he was uncertain about my HIV serostatus and that he wanted to know to whom he was speaking in terms of serostatus identity. His question

represented an intervention in the interview in the sense of clarifying subject positions and authority to speak. Andrew's question indicated that sero-identity informs the interview experience, highlighting the issue of representation and power I have already discussed in the section on my assumptions about qualitative interviewing. In this sense, Andrew's question can be interpreted as an intervention in subjectivity or even an engagement with power and the constitution of positionality in the interview. His question reveals how power, mobilised in the relations of speaking positions, informed the HIV experience interview. His question also suggested how power could be claimed by the interviewee in the practice of the active interview.

Ethical arrangements

Because the study involved NHS patients, ethical approval was required from the Local Research Ethics Committee. This procedure was derived from medical research where risks are seen to arise out of interventions such as the trialling of new pharmaceutical products. In accord with institutional guidance, ethical research practice concerned providing adequate information for the patient about potential harm so that they could make informed consent and also to ensure that participation was voluntary (Edwards & Mauthner, 2002). Ethical clearance for the study had been obtained prior to my employment as the researcher, so for the qualitative interviews, I was bound to use the procedures and forms that had been approved. These reflected the arrangements for the quantitative survey. The procedure involved using a 'patient information sheet' and obtaining voluntary informed consent in signed form. Forms were archived at the Royal Free and University College Medical School. The 'patient information sheet' had various elements. It provided an overview of the purpose of the research and how the data generated in the interview would be used. The information sheet also explained that the interview was confidential. It also specified how the transcripts would be

anonymised and that identities would be protected if quotations were used in conference presentations and reports arising from the research. The information sheet also outlined that the research was voluntary and that withdrawal from the study would not be connected with access to health care in the HIV treatment clinic. At the end of the interview, I also let the interviewees know about support services and counselling in the clinic if that was appropriate. As interviews were always held in the clinic, an interviewee could see a counsellor afterwards. I was also provided with regular 'clinical supervision' to help me debrief from my interview experiences.

As my research called for re-interviewing the participants, I completed another application for the Local Research Ethics Committee (see Appendix Three). This new procedure mirrored the first but specified that the data would be used for my doctoral research. On this occasion, the patient information sheet was recast to explain the re-interview study (see Appendix Three).

As I mentioned in the previous section, the interviews involved sensitive issues with implications for emotional well-being. There were many ways that the interviews broached sensitive topics, creating challenges for the interviewee and interviewer alike. One interviewee spoke about the illness and death of a partner. Another interviewee reflected on his declining health and that treatment did not seem to work for him. Others spoke about difficulties maintaining safer sex with partners. The interviewees also discussed rejection by sexual partners and how living with effective treatments could be an isolating experience. However, the interviews themselves did not appear to be distressing. Some interviewees were worried about the interview: "I was worried about some of the stuff that was going to come up" (Paul: 2). But for the most part the interviews did not appear to be overly problematic: "Well I'm still here so obviously I

don't find it unpleasant or invasive in any way" (Stephen: 2). Some even suggested that they had found the experience to be 'cathartic': "I enjoyed it. I think it's interesting to have a chance to talk about it because I don't talk about it to many people very much" (Kevin: 2). These excerpts suggest that although the interviews engaged with difficult topics, doing so was not so much of a problem. In a sense, the lack of any comments about discomfort in the interview experience is an achievement. And as suggested by one of the interviewees, the interview was an opportunity to reflect on some of the sensitive aspects of living with HIV and was therefore welcomed. It may be that the interview itself was a situation that legitimised talking about the difficult aspects of HIV treatment and sexual practice. The comments of the interviewees also suggested self-subjection in terms of the required altruism discussed in chapter three and in this chapter in connection with sampling bias. It may be that the interviewees were prepared to discuss their personal and difficult experiences because they believed that the research was useful. Altruistic research participation has characterised the HIV experience. Prior to effective treatment, and because of the traditional slow pace of drug approval, participation in clinical trials was one of the main ways that people with HIV could get access to experimental treatment that might have had some positive effects (Epstein, 1996). Research participation may therefore be seen as a matter of making oneself available for research and self-preservation. By extension, discussing difficult personal concerns and interview discomfort are seen as part of what is expected of patients receiving health care such as HIV treatment. Nevertheless, I contend that reflexive research practice requires that the sensitive aspects of research interviews are addressed during the preparation and conduct of qualitative interviews.

Analysing the interviews

The analysis of the interviews focused on language and meaning with attention to how

these helped mobilise narrative and discourse about living in the post-crisis situation, particularly preventing HIV. The analysis aimed to create a balance of theory and data (Ezzy, 2002). There were three main aspects to the analysis: iteration or reflective cycles of analysis and re-analysis; the gradual development of 'thematic' frameworks; and written justification of the themes. I attended to both converging and apparently contradictory accounts as ways of strengthening and challenging the credibility of the analysis (Seale, 1999).

This study relied on iterative processes of data generation and analysis of various kinds. For example, I reflected on what was said in interviews to formulate new questions inside and between interviews. I transcribed and listened to some of the interviews and made notes about apparent themes. I conducted a thematic analysis of the first 25 interviews and used this conceptual framework to help orient the questions for the re-interviews. Between the first interviews and the re-interviews, I reflected on other published research and debate and formalised my analysis in writing. This written analysis also provided a basis for orienting the format and direction of the re-interviews. These different forms of iteration had several benefits. Iteration helped me to make adjustments to future interviews in terms of refining questions and formulating new ones. Iteration allowed me to check my interpretation of meaning with interviewees and extended the research into new areas of inquiry.

The thematic analysis of the interviews was a somewhat hybridised process. One reason for 'hybridity' is that I developed as an analyst over the period of my research. In a more practical sense, I tried out different approaches and also moved back and forth between the interviews and the re-interviews and between analytical approaches. But, there were three main phases in the analysis: cross-case thematic analysis of the 25 interviews;

single ‘case studies’ of each of the eleven re-interviews; and cross-case analysis of the eleven re-interviews (see Appendix Four for two examples of how the qualitative analysis was conducted).

The thematic analysis of the 25 interviews was established using several techniques. Each interview was broken down into segments that related to the research topic. By comparing and contrasting identified segments of the interviews, themes were established, extended or collapsed. Comparing and contrasting enabled a gradual focusing of the meaning and scope of each theme and how they related to other themes. A constellation of themes emerged in this analysis (see Appendix Five for the thematic framework). Themes varied from major topic areas of the interviews, aspects of the interviews that supported or challenged some of the theoretical propositions I had developed about post-crisis discourse, through to examples of language use and metaphor. I organised the themes into a framework, where proximity was suggestive of some sort of connection in terms of topic areas or theory. As analysis proceeded, considerable adjustments were made to the themes, often necessitating reorganisation. Convergence and ‘deviance’ were important ways of focusing the themes. Convergence, or repetition in the interviews, around a question or concept drew my attention and was the basis for establishing a theme. For example, I collected interpretations of low viral load and risk of HIV transmission in sexual practice. These interpretations seemed to converge on the idea that low viral load was not taken as a reason to not have safer sex, suggesting a challenge to one of the orthodox explanations of risk behaviour among gay men with HIV (see Appendix Four). Another useful technique was to also work on contradictory quotations about the same subject. This approach is suggested by several methodologists as a way of promoting rigor in qualitative research, and is sometimes called “... deviant-case analysis” (Silverman, 2000: 180). I found that these

contradictions were often the most challenging and fruitful areas of theoretical development. For example, the interviews revealed some contradiction about the idea of low viral load. Some interviewees, for different reasons, did seem to believe that HIV transmission was less likely with low viral load (see the first example in Appendix Four). These examples contradicted those that converged on the idea that HIV transmission remained possible with low viral load. This contradiction also appeared to be more than a difference in knowledge, as positions on conduct in light of the riskiness of low viral load seemed to be independent of technical considerations. This contradiction led into an analysis of how, in a domain of uncertainty and contest such as with knowledge about low viral load, individuals were required to take a position on HIV prevention informed by ethical judgements about responsible conduct. In this way, an apparent contradiction led into the development of the idea of the ethical challenge of uncertainty and contest about treatment-related risk knowledge. Once I believed I had identified an important theme in terms of my interests in post-crisis, I wrote about it, organising my thoughts and trying to make systematic links back to the interviews. Sometimes writing lead to further reorganisation of themes.

For the eleven re-interviews, I analysed each as a kind of single case study with reference to their original interview and the thematic analysis of the 25 interviews. These case studies were on occasion 6000 words of written analysis. I found that this method of analysis contrasted with cross-case thematic analysis. This case-oriented analysis created much detail, particularly about the interview as a whole experience. Cross-case thematic analysis tended to 'cut up' or collapse interviews and therefore obscured the sense that interviews had an internal coherence, or that agency was expressed in terms of the aesthetic distinctiveness of an account. For example, the analysis of each of the re-interviews foregrounded individual self-care strategies in

different aspects of lived experience: diet, exercise, well-being, managing treatment and expectations for the future. Comparing each case study exposed to view a domain of aesthetic/expressive judgement concerning methods for living with post-crisis risk. The case studies however, presented a challenge for synthesis, partly because they tended to exaggerate the individualistic aspects of accounts of lived experience. At the same time I found that the cross-case thematic analysis to some extent avoided problems of synthesis, because it worked with a group of interviews. To explore this problem of synthesis, I also conducted a cross-case thematic analysis of the eleven re-interviews (see Appendix Six). This had the effect of dissolving the case study analysis into a thematic analysis, but with the richness of individual accounts at hand. For example, the re-interviews contained several examples of interviews talking about their approaches to self-care in connection with the uncertainties of treatment. These different stories and their connections with temporal horizon led into thinking about the negative and positive qualities of uncertainty related to treatment and life expectations (see the second example in Appendix Four).

Writing was the other technique of analysis. The entire research process was punctuated with moments of written reflection, moments that had the effect of generating substantive theory about the research topic. For example, memoranda were written to explain different themes. Technical reports were also written to summarise progress in the analysis. The case studies were written prose. These forms of analytical discipline had special significance in the context of the interpretive orientation of this study. Writing in its various forms has to be recognised as a site of production of meaning in dialogue with data generated in interviews. Through writing, the interpretive analysis exceeded the interviews so that a meaningful and theorised research account could be made available for consideration. In this regard the depiction of the research comprises a

genealogy of the favoured interpretation.

Addressing analytical bias

One problem of this interpretive approach to analysing qualitative interviews is the possibility of analytical bias. The research account could be construed as the story that I wanted to tell. It could be said that I made biased analytical choices, or foregrounded themes that supported my own orientation to post-crisis risk. This is a problem also in that my doctoral research was, in general, an individual effort. Nor was there scope for some of the team analysis methods held by some to guard against bias (Popay et al., 1998). However, as I have discussed in connection with sampling bias, analytical bias can be a problem in any research. For example, agreement between members of a research team may not necessarily mean that their interpretations are not biased. It could also be argued that disagreement between researchers is an equally valuable opportunity for theoretical development. There is also the notion that regardless of the various ‘techniques of objectivity’ that promote the reliability, validity or credibility of a research account in an academic community, there is always an interpretive moment, or as others have put it, an ‘ethnographic moment’ in the depiction of research findings (Scott & Usher, 1999). Even in the most exacting quantitative studies, the numbers have to be put to some discursive use in terms of some question or other. Researchers are required to make an interpretation, even of the most tentative kind. So it can be argued that interpretive qualitative methods are not alone in facing problems of biased interpretation. Moreover, there may be some advantages in qualitative methods that take the problems of interpretive practice into the design and execution of research at the outset.

However, I did use several techniques to promote the credibility of my analysis: deviant

case analysis; transparency; and a workshop about my analysis method. As I have already mentioned, one important technique was 'deviant case' analysis, which is a way of considering the adequacy of one perspective or another in light of 'contradictory' data. In this respect, interpretations were made that encompassed the range of themes and contradictions apparent in the interviews. Interpretations that could not be sustained were adjusted or set aside. Transparency was also another way of promoting the soundness or credibility of my research. This was achieved in the cross-case thematic analysis by making clear links between the data and the written justification of themes, or in the single case studies, using quotations to support and challenge the analysis. I was also able to find several ways of airing my work with colleagues to promote its credibility. I presented at conferences and published a paper (Davis et al., 2000; Davis et al., 2001; Davis et al., 2002). I also attended a qualitative analysis and writing workshop as part of the doctoral programme at the Institute of Education. For this workshop, I designed an exercise where I presented a theme from the published paper and linked it back through the supporting thematic framework, into the source data. This exposed for consideration, how I had moved from data to writing. The workshop also provided the basis for Appendix Four. The workshop experience was useful as it allowed others to comment in great detail on my use of data and written interpretation. Via these ways of addressing bias, I therefore argue that this research account is the story I want to tell. But I choose this story because I think it is a valuable account that will bear academic scrutiny.

Summary

This qualitative interview research concerns accounts of the lived experience of gay men with HIV, with particular reference to the advent of treatable HIV and sexual practice. The research is distinctive as it was conducted in a clinical setting and involved re-

interviewing gay men about their experiences of treatment and risk management in the post-crisis situation. A combination of cross-thematic and case-thematic analysis was employed. Qualitative methodology was justified because little descriptive work has been done about the experience of encountering aspects of post-crisis risk. The method is therefore necessarily 'illuminatory'. But at the same time, I have drawn on the critical perspectives supplied by narrative and discourse with regard to depicting lived experience. I have also acknowledged several perspectives on the practice of interviewing to do with sensitive topics, authorial voice and the medical construction of identity. These critical perspectives help move the research from the depiction of experience into an analysis of how and for what purposes these depictions are constructed, with particular reference to post-crisis risk governance. Put another way, this research addresses both knowledge and knowledge-making about living with post-crisis risk.

The following chapters address the themes of the analysis. Chapter five considers the meanings of the post-crisis experience. Most of the data presented in this chapter arose in the re-interviews, but some material from the first interviews is included. Chapter six explores innovation and imperative connected with treatment and prevention and some implications for identity. It is almost exclusively based on the re-interview material. Chapter seven discusses the uncertain and contestable aspects of the risk meaning of two key aspects of HIV medical technology: reinfection with drug-resistant virus and viral load and infectiousness. This chapter uses data from all of the interviews. The argument is supported by exemplary and contrasting quotations edited for readability.

... of course the answer, I think, is to keep on living in the day with the knowledge that what you do today has to be a part of a process of moving into the future ... (Michael: 2)

Introduction

This chapter addresses the first problematic identified for this thesis: the meanings of post-crisis for gay men with HIV. As such, this chapter is an important step in the development of the thesis. The idea that treatment influences the HIV prevention practices of gay men with HIV, most often represented as treatment optimism, relies on some sense of the recession of the seriousness of HIV infection, or post-crisis. However, as noted in chapter two, this treatment optimism idea has conceptual limitations and appears to have been applied with little dialogue with gay men themselves about what the post-crisis situation means to them. Therefore, I will explore the interview accounts to identify and discuss post-crisis meanings. In particular, the chapter focuses on the advent of treatable HIV and the different meanings of HIV and AIDS. I will use the idea of manufactured uncertainty to suggest some revisions or challenge aspects of post-crisis discourse and therefore provide a basis for reconsidering the links between treatment optimism and risky sexual practice. This discussion also identifies some of the challenges that arise for gay men with HIV in connection with the uncertain qualities of treatment and some of the implications for HIV prevention. The chapter has two sections. In the first, I explore the meanings of accounts of the advent of the treatable HIV. In the second, I address the different visibilities of AIDS and HIV.

Accounting for the advent of treatable HIV

In this section, I address several aspects of the personal accounts of using HIV treatment in the post-crisis situation. I will explore ‘turnaround’ narrative and some other accounts of change connected with the transition to effective HIV treatment. The discussion draws attention to the mixture of unfolding hope and proliferating uncertainty that appears to inform personal security. It considers life expectations in the post-crisis situation, which, contrary to the public representations of post-crisis, appear to be either out of the question, or rather modest. In post-crisis, HIV appears to have the property of returning in unexpected forms, foregrounding the need for surveillance of the self and the prescribing practices of the clinic. For these reasons, interviewees focused on methods of self-care that helped them to manage the uncertainties of the treatment experience. But uncertainty was not always a negative aspect of experience. It also seems that the manufactured uncertainties of HIV treatment have value for gay men with HIV as they provide the basis for resisting the limiting prognoses of HIV medicine.

‘Turn around’ and other engagements with HIV risk

The accounts of the experience of the advent of treatable HIV do not altogether support the idea of a general linear form to risk. Specifically, medically determined ‘turnaround’ is one possible history among several. Other biographical forms include a traditional form of ‘body blow’, a more metaphysical sense of prophecy and a risk-oriented installation and exchange of liminalities. These different engagements with risk provide the basis for questions about some of the assumptions of the post-crisis order, in particular, a universal ordering of risk and HIV medicine. Even though this challenge to a normative post-crisis discourse arises in an analysis of the accounts of a small group of gay men, the existence of these variations is sufficient to raise a question over how the advent of effective treatment is typically constructed. Moreover, support for this

more tentative understanding of the post-crisis situation is also emerging in the published literature. For example, Rosengarten et al have suggested how expectations among HIV doctors have been adjusted since the initial ‘euphoria’ of the mid 1990s (2004).

The interviewees depicted life on treatment as generally positive. For example: “... fine, physically very good” (Paul: 2), “... fine, fine” (Thomas: 2). Some of the interviewees did refer to health problems: “... pretty good really on the whole ... there’s not been any great changes apart from a couple of health scares this year” (Michael: 2). The interviewees also suggested that the management of treatment had taken on central importance, for example:

... not badly at all. I changed my drug regime about this time last year onto Nevirapine [treatment], dropping the protease inhibitor [treatment] because I was getting minor encounters with kidney stones all the time and they were very painful (Kevin: 2).

This account suggests a transfer of concerns from health per se to the negative health consequences of treatment itself, creating a new focus in risk management on the appraisal and management of treatment. In this way, variation in health as such was mixed with treatment choices and effects:

... ups and downs. I don’t know, did I have the problem with the Abacavir [treatment] when I saw you last ... It was the Abacavir I think, because they put me in hospital for a couple of weeks (George: 2).

It seemed that treatment was welcomed but that its unwanted effects were a focus for the interviewees. The illness experience seems bound up with the manufactured

problems of treatment effectiveness and side effects. It seems possible to argue that concerns over health have become mingled with concerns about maintaining the positive effects of treatment and reducing its unwanted side effects. Several men referred to negative health experiences, some of which were attributable to treatment, such as disfiguring abnormalities of fat distribution, diarrhoea and sleep disturbances. Several spoke of poor emotional well-being, including speaking about suicide, depression and problems with relationships. These accounts suggested how difficult living with HIV treatment could be.

Some interviewees spoke of turnarounds in their life expectations. Interviewees who had been ill spoke about how their health had improved, with more energy, weight gain, overcoming infections and returning to work. For some men, these changes had been dramatic ‘turn-arounds’ of previous expectations and therefore echoed the narrative research discussed in chapter two (Brashers et al., 1999; Ezzy, 2000; Pierret, 2001; Trainor & Ezer, 2000). Several of the men said that they had expected to die:

I had the HIV test and it came back positive and I just wasn’t expecting it at all, and so I didn’t drink, but I smoked more and more and more, thinking I’d be dead in two years ... in 1991 it was HIV equals AIDS equals death (Michael: 2).

In this example, Michael referred to a period of the HIV epidemic when there was no effective treatment. In this situation, there was little hope: “... it was AZT, there was no other hope and that wasn’t a hope you know. Everyone I knew on AZT was dying” (Michael: 2). AZT is a HIV treatment introduced in the late 1980s. As discussed in chapter two, on its own, AZT was not an effective HIV treatment. Michael’s construction of AZT and hope resembled the theorised links between hope and treatment explored in chapter two. He therefore creates a picture of the previous

situation for gay men with HIV that contrasts with post-crisis accounts. However, it was also possible to exceed the poor life expectations of that period: "... when I was diagnosed I was given five years and I superseded that by one year. I'm overdue death by one year" (Michael: 2). George related a similar experience:

George: ... when I was first told I was HIV positive I was told I had seven years to live. So I tried to cram everything in ...

MD: When was this?

George: Fifteen years ago. So I just tried to stick as much into my life because then people were actually dying. And there was no such thing as drugs, oh they had fucking what was it, AZT around at the time. And it was the only thing they had and they're still dying on that anyway ... I resigned myself to the fact seven years is what I've got and that's what I was working at. And then fucking eight years came along, then nine and ten: "What the fuck's going on here?" (2).

These quotations positioned the authors as the beneficiaries of superseded predictions or as incredulous observers of their own survival. Importantly, these experiences were not always attached to the advent of treatable HIV. This distinction is salient because it reveals how some post-crisis constructions of the advent of treatable HIV associate improved life expectations with the advent of treatment alone. It seems possible to suggest that some interviewees had experienced a situation where they had already exceeded prognoses when they began HIV treatment. The post-crisis situation is therefore not necessarily a straightforward, medical watershed in lived experience. There was also a suggestion that 'turn around' also referred to the reputation of HIV treatments such as AZT. AZT is now used in combination with other drugs with great effect (NAM, 2003a). So it can also be argued that 'turnaround' implies a reversal in the reputation of treatment per se. These nuanced turnaround narratives help instantiate the

post-crisis order because they depict the transformatory powers of HIV medicine. But they also reveal a complex history of HIV treatment and hope.

It was also apparent that there were other post-crisis accounts of living with HIV treatment. Kevin provided an account where he was diagnosed with HIV infection after a life-threatening pneumonia and after the advent of treatable HIV. Kevin spoke of realising that he "... actually might die" but that through treatment he was able to return to work (1). This is not a turnaround narrative as such. In this account the experience of illness and diagnosis is positioned in the post-crisis situation. A relatively sudden and life-threatening illness was depicted as the "... body blow" (2) that precipitated diagnosis and therefore altered the life-course. This kind of account therefore deploys a traditional illness narrative (Hyden, 1997). Another possible story of living in post-crisis was a kind of prophecy of infection:

... I remember being at school and our science teacher said we were discussing the, you know, HIV had just come out, and he said at least one person in this classroom will be HIV positive, you know it's inevitable ... (Edgar: 2).

This account expressed a different sort of engagement with HIV risk. It turned the science of prediction into a sense of the inevitable, as if risk calculations revealed individual fate. This depiction of experience was not turnaround or biographical disruption as such. For example, according to Edgar, it was: "... really difficult to pinpoint any major change in my life" (2). Another similar orientation to living with HIV was a adaptation: "I think I've grown into it" (Andrew: 2). Prophecy and the notion of a developmental narrative make HIV infection seem to be part of the order of nature, or outside of reflexivity. Another accounting strategy involved a kind of anticipatory self assessment and risk management:

I knew what I had done, I sort of suspected I probably was HIV positive. but whilst I was, I felt well I don't see the need to have a test, which I don't now agree with really, but then thinking about it, at the time there was, treatment was sort of very much in its infancy. So maybe I was right, I don't know ... (Robert: 2).

Robert gave an impression that he diagnosed himself and delayed testing until he was confident with HIV treatment. Robert's account traces out a strategy for dealing with HIV that moves from living with the possibility of HIV infection to living with the possibility of cure. Via different sorts of engagements with medical technology, one liminality was exchanged for another. These differing stories somewhat undermine the idea of a universal post-crisis experience or engagement with the advent of HIV. But they are unified in the sense that they each express active engagement with the meanings of risk or kinds of self-surveillance under conditions of uncertainty.

Ambivalence and insecurity

The accounts suggest that living with HIV treatment was a deeply provisional and ambivalent experience of expanding hopes and proliferating uncertainty. Such a depiction of post-crisis is consistent with the Ezzy's argument about the continuing uncertainties of life after the advent of effective treatment (Ezzy, 2000). The present analysis also underlines the kinds of benefits and drawbacks of using HIV treatment described in some recent policy research (Rosenbrock et al., 2000). But the depiction here also raises questions about how useful it is to think of HIV as normalised or bracketed with other chronic and manageable conditions. In particular, there is a suggestion of a separation between public and personal understandings of post-crisis, which is itself a source of frustration for gay men living with HIV.

Uncertainty attached to living with HIV treatment gave rise to a sense of personal insecurity. For example, treatment was not seen as wholly effective: "... they haven't taken away this life-threatening virus, which could eventually kill the person and very likely will do" (William: 1). But uncertainty was tempered with a sense of the radical achievements of medicine: "... we've come a long way in 20 years" (Robert: 2). The accounts therefore gave the impression that life expectations were not fashioned as categorically restored, but neither was there a sense of imminent death:

... it's becoming more optimistic, but it's still pessimistic. No-one believes that there's a cure there yet. No-one that I know, anyway. No-one believes that we're going to be cured in six months time or there's a cure round the corner in twelve months time. All I understand is that there's things to help ya stay alive but there's nothing there to keep you alive yet ... (George: 1).

George made a distinction between stay and keep, suggesting that treatment represented a method for staying alive until a cure became a reality. This sense of peril was traced into the provisionality of treatment: "... I'm conscious the drugs won't work forever" (Andrew, 1). Judgements about possible futures were attached to knowledge about risk derived from medicine:

... the first thing that could happen is the drug therapies could begin to fail, but on past evidence there's no reason why that should happen. It may be that with the passage of time all drug therapies fail, I don't know ... I might well find that I live with this chronic sexually transmitted illness for a substantial period of time and that this period may well be punctuated by periods of ill health ... I don't feel that I'm terminally ill ... (Kevin: 1).

Kevin's use of "... on past evidence" suggested a close engagement with the risk

assessment methods of medicine. It can be argued then that a key-note of these interviews was a hedged hope or an ambivalence of insecurity and hope. The men depicted their expectations as simultaneously “optimistic” and “pessimistic”. Phrases such as “... going to die”, “... eventually kill”, “... the virus will ultimately become resistant” point to the cautious quality of life expectations and how these were bound up in the ‘calculability’ of treatment effects. There was also a sense in which these requirements produced different and unexpected challenges for security:

I’m finding it quite difficult to come to terms with being healthy. It’s wonderful and it feels great every day, but in spite of all my positive thinking, I’ve expected to die for a long time I think. And it feels quite difficult to just think about living for a length of time ahead of me (Michael: 1).

This account foregrounds the idea that the possibility of an extended life creates challenges for gay men living with HIV. This engagement with “... being healthy” was also difficult because there was an enduring sense of the incompleteness of the effectiveness of treatment:

... how am I going to cope with life not being under a death sentence? What do I do now? Because, you know, the other thing is, you can’t quite believe that’s where you are, because we are not there yet, that’s the thing ... so when you hear the friggin’ Daily Mail say, you know: ‘AIDS is now a manageable condition like diabetes’. You think: ‘Yes, well, no, actually, no’. Treatments fail. People have problems. People have to come off treatments. Things go wrong. What do you do then? (Michael: 2).

This quotation also suggests a separation between public and personal representations of the post-crisis experience. In the news, the HIV epidemic is tucked inside the rubric of

‘chronic manageable disease’. Lived experience however, appears ‘messier’ and more provisional.

Reiterating risk

Another feature of the interviews was the notion of the revisibility of risk. In chapter two, I outlined some of the important risky aspects of HIV treatment, in particular the idea of reinfection. The idea of reinfection is detectable in the technical literature that preceded the advent of treatable HIV. However, I want to assert that in post-crisis, ideas like reinfection have gathered force, particularly as a focus for the regulation of the risk practice of gay men with HIV. Moreover, the interviews provide reason to say that treatment-related risks are open to superimposition or a kind of re-playing in unexpected forms. As I have argued, notions such as reinfection reflect the “... manufactured uncertainties” of HIV treatment (Beck, 1998: 12). And like other research, the foregoing discussion in this chapter has established that HIV medicine has some implications for ontological security (Macintyre, 1999; Roth & Nelson, 1997). But I will argue that HIV medicine is subject to the replaying of the viral and social actuality of HIV infection and that such reiterating risk has found new governmental properties. Superficially, post-crisis discourse is designated as an era of public complacency and private risk taking, treatment optimism and as a clinical practice of managing ‘normal’ chronic HIV disease. Conversely, it is possible to argue that the idea of iterative risk allows risk governance to proceed into, and proliferate in, the post-crisis context, where HIV risk can find new applications and regulatory application in the containment of HIV.

This sense of reiterating risk emerged in accounts of managing treatment side effects. Michael provided several accounts of how careful he had been to explore both holistic and traditional medicine in the process of an optimum regime of self-care:

I know that I am maintaining my health to the best of my ability and the drugs are maintaining the HIV at a low level, to the best of their ability. And I work with that (Michael: 2).

In this account, Michael positioned himself as a prudent manager of his own health as a way of optimising the effects of HIV treatment. However, this sense of a subject coordinating a health regime to best advantage was undermined:

... when I came down with the KS [cancer], you know, after what, three and a half years of working on myself and doing all this stuff, I was furious. I was outraged that this should happen to me after all of the work I'd put in, you know. It was like, no, I was in control here. But of course, I wasn't in control. But at least I was doing myself some good and I think it would have been a lot worse if I hadn't ... (Michael: 2).

Michael's account expresses frustration. Despite his efforts to improve his health, a serious illness occurred, questioning his reflexive capacities. Michael's account therefore suggested how "control" was in question in relation to the management of HIV infection and treatment. Also engaging with the idea of managing the self, Michael related how he chose to cease treatment to give his body a break from the rigors of HIV treatment and to counteract the side effect of lipoatrophy, a sunken look to his face. In this account he uses the term "re-conversion":

So what happened was exactly the same as when you introduce HIV into a body, which has never seen it before. So in some ways it was a seroconversion. It was a kind of re-conversion. It just did exactly as it would in a normal body when it's never been infected before ... (Michael: 2).

Michael's accounts suggest how HIV could re-emerge in reflexive treatment, undermining the sense of personal control over one's health. There were some other ways that HIV could re-emerge. Kevin related an experience where one of his treatments was altered due to diarrhoea. According to Kevin, an error had been made where his prescription had been reduced to half-strength. Apparently, to reduce Kevin's diarrhoea, the doctor had reduced the frequency of the dose, but also without increasing the strength of the tablet. This story about the unevenness of prescribing is significant in a general HIV treatment situation that places emphasis on correct dosage at all times to maintain the effects of the treatment. However, Kevin related how his viral load remained acceptably low and little harm was done. But Kevin also noted that this was his second prescribing error (an experience also mentioned by Andrew). In response to this kind of risk, Kevin said that he had adopted a practice of personally matching the drugs he was given with the prescription. Kevin provided a picture of a vigilant patient, surveilling not just himself, but the provision of HIV medicine and the possible 're-emergence' of HIV. Using HIV medicine was not a simple matter of making oneself available to medical expertise. Engaging with HIV medicine emerged as self-management of the irregularities of the capacities and practices of medicine itself.

It seems that HIV treatment is implicated in the (re)production of HIV. This iteration of HIV risk is a variation on the idea of manufactured uncertainty. HIV is returned in the post-crisis situation via engagements with treatment side effects or problems in clinical practice. It seems that in post-crisis, a particular intensification of the vigilant patient is mobilised around the various manufactured uncertainties of HIV treatment (Armstrong, 1993). And it also seems that post-crisis implies a different ordering of the risks of treatment and HIV. The interviewees were focused on personal engagements with treatment, but HIV was seen as always ready to break through.

These provisional and precarious qualities of the post-crisis experience created challenges for a personal sense of future. Watney has also identified this mixture of hope and insecurity: “What a luxury it would be ... to take hope for granted. We are nowhere near that time yet, but at least it is *imaginable*” (author’s emphasis) (Watney, 2000: 273). Watney’s comment underlines the value of the idea of living without having to reflect on uncertainty. In this view, the post-crisis experience can be understood as informed by heightened awareness of the possibility of a different form of life.

For the most part, the interviewees preferred depictions of cautious and ambivalent personal expectations of future. Robert articulated a sense of going forward: “... I do actually feel now that I do have a future” (2). However, for others the concept of a future life was either untenable or limited. Paul reckoned that a future was impossible to engage with: “... there isn’t a future ... I have to wait and see” (2). Long-term plans were not feasible: “I don’t really think about long term, you know, I kind of think in terms of the next few months” (William: 2). George explained this predicament in connection with hope:

I've got no plans to make any plans. I'm virtually living from year to year, month to month. I don't plan any further than a month down the track. I don't see any point to it at the moment. Because if I have to think about it then I don't see any light at the end of the tunnel just yet ... Certainly don't want to start building up my hopes and find out, six months down the track: ‘Oh sorry to tell you, but those tablets have stopped working on you now’ (George: 2).

It seemed that the better strategy for dealing with uncertainty was to suspend hopes and

plans or even the construct of future. Andrew found the idea of the future unintelligible:

MD: So how does it make you feel about the future, what do you think will happen?

Andrew: What a question to ask? What do I think is going to happen? How can anyone answer that question? ... I mean it's so open-ended (2).

These quotations gave the impression of a suspension of future and an attendant bracketing out of the reflexive capacities of the individual. This suspension can be seen as a reversal of the way reflexivity is depicted in the governmentality literature. For instance, such literature makes much of the notion of the positive production of self or the notion of the 'becoming' of the reflexively made life course (Lupton & Tulloch, 1998). In these post-crisis accounts, it may be that reflexivity is bent to a different sense of living in time. If not suspended altogether, the sense of the positive production of self or future horizon was truncated:

... I feel very well, you know, that's sort of the main thing isn't it. You know, and I think I'm 40 and, you know, if each drug I'm on lasts for 2 years then, you know, I might be around 60 ... I think for a gay man 60's probably enough ... 60's not a bad innings ... none of us know until we've been there ... (Robert: 2).

Robert seemed to accept a limited lifespan based on his estimations of how far into the future different treatment options were likely to take him. This sense of retiring into death appeared in other accounts of men of similar age (40ish): "... I'll live until I'm about 60" (George: 2); "... I don't think I'm going to get worked up about having a lifespan that ends at 62 instead of 82" (Kevin: 2). It was as if treatment was seen to provide an acceptable term of existence that roughly corresponded with a working life.

This seemed to be a notion of a good enough existence considering the known effectiveness of HIV treatment and its drawbacks. But this good enough existence, via uncertainty, was also open to revision:

In the back of my mind is the notion that it would be quite nice to be the first person cured of AIDS, but until they invent a cure, that might be a bit difficult to achieve. I have no other specific thoughts. But I mean at 55 I'd like to be retired. And I think it's quite likely I'll be here when I'm 55 and not dead (Kevin: 2).

Caring for the self in post-crisis

The precarious and provisional qualities of the HIV treatment experience were linked with various expressions of how best to shape one's conduct in terms of survival. The interviews contained many examples of self-care in the ordinary sense, such as adhering to prescriptions, exercise, dieting, reducing tobacco smoking and alcohol intake, meditation, using vitamin supplements and organic food and so on. But the analysis also suggested different orientations to care of the self. These orientations had the effect of describing personal responsibility for risk management bent to the precarious quality of treatment. In this sense, these methods can be seen to comprise a kind of aesthetics of self-care (Lash, 1993). I also want to argue that this aesthetics of self-care is figured around the production of a surplus of a certain form of uncertainty that has positive value.

The self-care methods offered by the interviewees comprised: gaming, positioning, conserving, settling and normalising. One approach was to develop a planned approach to self-care that engaged with risk: a "... game plan" (Stephen: 2):

... then I had my game plan for the future, which was look after myself. I mean this probably means a bit more, is actually take bad use of bad word, positive

steps to look after myself as opposed to let my whim look after myself. This is going to the gym ... (Stephen: 2).

This account constructs self-care as a deliberate and self-aware reorientation and management of life-style. “Game-plan” resonates with risk, forming self-care against a HIV. This strategy could also be about caring for and improving the interior, psychological self:

... the way to prevent the onset of AIDS was about living a healthy lifestyle in every way ... cut out a lot of the toxins ... working on lots of mental issues all of my past and clearing all of the garbage out ... (Michael: 2).

This account suggests an aesthetic value of purity of body and mind that provides the basis for effective and sustained self-care. Such self-care could be also informed by knowledge gained from the health care accounts of long-term survivors:

... all of the studies and surveys of long-term survivors as they were called then, people they said could of been infected ten or more years ... It was all of the people that were still alive they had started to collate information as to what they all had in common. And so I went for it ... I felt empowered. I felt I could do something, which a lot of people I knew didn't. And I had a friend who was diagnosed several months after me, who within a year and a half was dead ... (Michael: 2).

The account suggests a narrator harvesting methods of surviving using the knowledge derived from other people's experiences. Tellingly, the interviewee also refers to “long-term survivors” as an outmoded term (Michael: 2). A key to health was an integrated system of care that embraced, but exceeded, mainstream medicine. This was a kind of

placing oneself in the best possible position to deal with HIV infection and to optimise HIV treatment. In an effort to find a good 'position', one could draw on the example of people who had surpassed official prognoses and who had apparently used methods of surviving that were not strictly medical. The account seemed focused on optimising the self in light of orthodox medicine and lived experience. Preparation of the self was also valued in relation to the ongoing management of treatment. In the next example, the interviewee refers to preparing himself for a second round of treatment:

... because I knew that I would have to go back on to the drugs and I was doing all the investigating myself preparing for it, or I was preparing for the worst I suppose, probably, slapped back on PI's [treatment] and thought: 'Oh no'. But once I got over the hurdle of, my own mental hurdle of my attitude changed, my attitude has actually changed towards the drugs and HIV is not such an issue for me anymore ... (Andrew: 2).

This example emphasises the importance of emotional preparation of self, centring on an acceptance of the treatment experience. Another method was conserving the self. Kevin used the emotional meaning of the word 'patient' to denote his approach to the future with HIV treatment, either in terms of social relations: "... but now I've changed, and in fact I've a bit more patience with people, I'm a bit more circumspect" (2), or in connection with energy: "... I've learned to be a great conservator" (2). To construct this method the interviewee referred to psychotherapy: "... I have acquired some kind of subconscious technique" (2). Relevant techniques included: distractions, reinforcing "easily achievable targets", striving for "psychic balance", being aware of negative thoughts, re-thinking social relationships, leaving too hard things to one side and avoiding stressful HIV support groups that would draw on his energy (Kevin: 2). This method had the benefit of promoting self-care:

... now if you'd have said that I could have dealt with a possible cancer diagnosis with phlegmatism in any period prior to this period, I'd have said: 'No. I wouldn't be able to do that'. I would, you know, I'm a bit hyper about things and I'd probably have reacted very, very, negatively to it, and with a lot of emotion. But in fact I didn't even tell people ... a change occurs here at some point. Partly it's forced on you, because you're too tired to be anxious and angry about stuff. And it uses up far too much of your energy to be annoyed and worn out and pissed off ... (Kevin: 2).

This method concerned conserving the self or of reserving energy in face of the required long-term engagement with HIV medicine. In this approach efficiency was a keynote: "... a much more efficient person ... I make sure I expend as little energy into it as humanly possible" and "... it's a sort of jog-along future right now. I tend to have abandoned great plans" (Kevin: 2). Kevin used an interesting phrase to characterise himself and his social relationships in the situation of HIV diagnosis: "I've got this fragility" (1). Self-care was informed by the idea that HIV disease had become a 'potential' rather than an actuality:

... in the back of my mind there was the notion that maybe I will be dead in three years and, you know, so really I take each day as it comes and I, you know, whatever I can take out of my life I enjoy ... I think the whole question of HIV treatment and what helps HIV positive patients is in such a state of flux now because instead of being basket cases they've all become people carrying the potential to be a basket case but who can go straight back into life. And I don't know of any other illness where we have any kind of parallel learning that we could transfer over about how people are meant to cope with that. And so I think we're all on new territory, and it's pretty tough territory (Kevin: 2).

This construction underlined the precarious and personal quality of living with HIV treatment that led into a kind of vigilant, resigned conservation of self in life with treatment. It also constructs the HIV experience as exceptional and therefore different from other illnesses because of its latent life-threatening quality.

A harmonising survival method was also reflected in accounts of living with treatment: "... period of equilibrium" (Stephen: 2). Stephen spoke of taking treatment as a "... settlement period where I actually felt comfortable and I realised that I'd got all this sorted out because I wasn't getting ill" (2). Stephen spoke of wanting "... a settled life" (2): "... well I don't really think about it, because my life is, I mean, you know, settled" (2). There was some ambiguity to this use of 'settlement' where it could mean that a future was stable but also that it was laid out in a certain way. Andrew used similar words, saying that he was "... more centred", "content" and "calmer" (2). These strategies resemble the strategy of conserving the self. But they also connote post-crisis, or of the quelling of uncertainties about the future.

Yet another self-care method was normalising. It was typified by: "... I try to let things wash over me " (Robert: 2) or "I don't let it get on top of me, deal with it now and then, it's fine" (Andrew: 2) and "I think I've grown into it ... I'd say I've got used to it" (Andrew: 2). Similarly, regarding AIDS as extraordinary was not relevant:

Robert: ... and I'm sort of more disciplined about doing exercise. But, you know, you should be anyway really, so I feel good after I've done exercise.

MD: But have you instituted these practices because of HIV or ...

Robert: Yeah, initially it was because of HIV I think, but it's sort of become a routine if you like ... sort of a way of life really. So I'm not sort of conscious,

I'm not thinking oh I must go to the swimming pool to exercise because of my HIV, you know, I'm not really very conscious of it. And people say the drugs are a constant reminder, I don't think so. I mean I take vitamins every morning, you know, and you don't think about it do you, what you're taking and why ... (2).

In this strategy, the HIV treatment experience is depicted as non-exceptional. Self-care was figured as routine. Life with HIV treatment is constructed as part of the everyday practices of self-care. In this orientation to living with HIV, a normative healthy self is a reference point for self-care activity. And this normal self is achieved by bracketing out HIV. This normalised approach contrasts with those where self-care is predicated on preparing and enhancing the body for HIV treatment. It also contrasts with the notion of the HIV experience as exceptional, for example: "... potential to be a basket case" (Kevin: 2). Routinisation or 'making ordinary' was summarised by adjustment and adaptation:

I'm quite adjusted to HIV, so I'm not crying yes things do get me down sometimes, but I think I'm ok really yeah, I think you know, I'm doing all right ... (Robert: 2).

Gaming, positioning, conserving, settling and normalising are 'technologies of hope' that bring into being different methods for managing the self in post-crisis. The methods reveal how, in various ways or with various emphases, the self with HIV 'invests' in, or furthers a kind of beneficial uncertainty. The methods are open-ended: they are ongoing and have no closure. The methods are therefore figured to optimise the possibilities and capacities of HIV treatment and in that sense are open to uncertainty as opposed to calculation. They do not work to resist the manufactured uncertainties of HIV treatment, but they have the effect of dividing it into insecurity and possibility or transforming

questions of insecurity into possibility. Post-crisis self-governance therefore extracts value out of uncertainty for the purpose of survival. O'Malley has suggested that uncertainty has value for neo-liberal social relations, precisely because profit can be made out of uncertainty, as in contract law (O'Malley, 2000). If HIV treatment was a closer approximation of cure, the notions of risk, fragility and uncertainty would be less important. In the absence of cure however, uncertainty has some positive value for life expectations and therefore methods for cultivating it are important. The accounts alert us to the ambivalent quality of uncertainty and how HIV treatment, in its broadest sense, and perhaps medicine in general, is also about realising the positive value of uncertainty.

The value of uncertainty for resisting medical prognoses

The interviewees also suggested that clinical prognosis of life expectancy was a contested domain. Sontag in writing about AIDS in 1988 presaged post-crisis in a statement about the interplay between calculability, uncertainty and the governance of the present:

Being able to estimate how matters will evolve into the future is an inevitable by-product of a more sophisticated (quantifiable, testable) understanding of process, social as well as scientific. The ability to project events with some accuracy into the future enlarged what power consisted of, because it was a vast new source of instructions about how to deal with the present (Sontag, 1988: 89).

The proliferation of techniques and knowledges in the area of HIV medicine, particularly those that attempt to predict future horizons, can be seen to have also intensified questions of ontological security and mobilised particular forms of self-management. But this question of calculability and uncertainty is not necessarily

restricted to the advent of treatable HIV. As discussed in chapter two, working in the late 1980s and early 1990s, Macintyre found that long-term survivors had considerable trouble dealing with the ways in which their life expectations were undermined by the idea of calculable futures (Macintyre, 1999). The following quotations provide a sense of how prognosis in the post-crisis situation is also bound up with the clashing of hope and calculation:

I said to my counsellor in this room: 'Well how long have I got?' She said: 'Oh you mustn't look at it like that love, it's more like diabetes these days'. Which is a kind of brave thing for her to say to somebody with a CD4 count of 20 at that point. She said: 'You know, it's a sort of chronic illness rather than a terminal one, and people are living for years with high quality lives on combination therapy already'Well I mean what she was trying to do was put me in the most positive frame of mind ...

[later]

My doctor is much more sort of tight-lipped and less upbeat about saying things I mean she looked at my results first of all and I had a CD4 count of 20 and a viral load of 164k, I'd just had pneumonia and about six other things on the sheet, and here I was developing KS. So my doctor wasn't going to say, because she's not the disposition of that kind of person: 'Oh it'll all be fine darling'. She wasn't going to say that. In fact she told me I had a 60% chance of dying within the next 36 months (Kevin: 2).

These accounts contrast different forms of prognostic expertise and different orientations to life expectations in the post-crisis situation. The former signifies an attempt to install or foster hope. The latter is more calculating and therefore limiting. Each represents an intervention in uncertainty. But their combination is a dilemma:

I thought well: ‘I wonder what that means?’ And, I thought well: ‘There’s nothing you can do about it, and there’s nothing under the sun you can do. If it is likely that you’re going to die in that three year period there, then it’s just going to happen and that’s that’. You know, the only stuff you can do is to make yourself feel like you’re doing everything you can. Which is the sort of feeling we all want isn’t it? I’ve done everything I can, there it is, is to eat the way they suggest. Take the pills like they suggest, you know. Take exercise like they suggest and don’t be a bloody fool ... (Kevin: 2).

The phrase: “... don’t be a bloody fool” is a kind of self-remonstrations. Stephen also had a story about prognosis: “I was told by the clinic downstairs that my life expectancy’s between five and ten years” (2). Like Kevin, Stephen provided an account of a self trying to navigate through the contradictions of uncertainty, calculation and hope: “I thought I was going to be around for a very long while, but, you know, look at the cohort study and that’s the probability apparently” (2). It seemed that the prognosis may have been based on a cohort study of men in the clinic. We can speculate that the average lifespan of these men was used to estimate Stephen’s. Stephen’s account is therefore wrought with ambivalence. Calculating life expectations was seen as: “... not actually an unreasonable thing to do in statistical terms” (2). But resistance was also needed: “... there’s no fact I am definitely going to live for a particular period of time” (2). In this statement, Stephen brought together prediction and the unknowable. It seemed that the hope that arises in uncertainty promoted self-care, but that this reflexive orientation to the future was undermined by the calculations of HIV medicine. Kevin’s and Stephen’s accounts were also striking in that these problematic prognoses had been provided after the advent of treatable HIV. There is therefore something of a contradiction between the post-crisis notion of turnaround and these more technical

forecasts. And these accounts also reveal a paradoxical quality to uncertainty. It seemed that the uncertainties concerning treatment effects mobilised insecurity, anxiety and frustration. But uncertainty was also a basis for hope and a therefore a way of resisting limited, prognostic calculations.

Post-crisis visions of AIDS and HIV

The accounts of using HIV treatment therefore suggest engagements with hope and uncertainty which challenge orthodox constructions of the post-crisis experience. The interviewees also expressed a separation between the personal and the public visions of AIDS and HIV with implications for how both HIV treatment and prevention are understood. In this section, I want to suggest that as a matter of a kind of 'morality of ailment', HIV infection is experienced as keenly privatised and particular and that AIDS is made to disappear from view. AIDS is less visible as an objective medical condition and therefore as a way of signifying personal engagements with illness. In post-crisis, AIDS has been exchanged for a system of treatment where medicine engages with a techno-scientific project of controlling the virus and the patient is abandoned to the challenge of personal well-being. And while HIV is experienced as a personal matter, this private experience of HIV infection is further divided into determinate/indeterminate. If there is a universal post-crisis effect, it may be an ascendant, technologised, private, and therefore less visible, HIV epidemic. This analysis is important for understanding post-crisis discourse, particularly that about the effects of treatment optimism in the sexual risk practice of gay men with HIV. This dispelling of AIDS and the privatisation of HIV infection coincides with and helps constitute the erosion of the meaningfulness of AIDS as apocalypse and its capacities to mobilise self-protective practices, but also amplifies the treatment and prevention considerations for gay men with HIV. I want to argue that the notion of the impact of

treatment optimism in sexual risk practice has ‘missed the point’ of post-crisis. It is AIDS and its cultural position as a form of apocalypse that has changed, while HIV risk endures in the lived experience of people with HIV infection.

In the following discussion, I trace out this argument in connection with supporting data. First I address accounts of how AIDS in particular appears to have a different definition in post-crisis and also the related notion that work is required to make HIV disappear. I then consider several separations in the meanings of HIV treatment to do with determinacy, trust and responsibility. I also consider a public/private divide that appears to have implications for HIV prevention.

Redefining AIDS

In chapter two I noted how post-crisis is characterised as the era of chronic manageable infection or in other discourse how, via HIV treatment, the HIV epidemic is ‘normalised’. As suggested in the previous section, these ideas were not altogether accepted by the interviewees. However, it did seem that AIDS was understood differently, with significant implications for sense of self with HIV infection. The prospect of a changing understanding of AIDS in the post-crisis situation was also managed in accounts through a cautious piecing together of objective knowledge derived from experts, often via the device of reported speech. It seemed that the enormity of the idea of a change in the meaning and presence of AIDS meant that the interviewees had to call upon external experts to verify their perspectives.

For the interviewees, the idea that HIV infection was permanently manageable was unproved due to the short period of time since the uptake of treatment:

I don't think it's perceived as a chronic manageable illness. Not in my experience.

It might be, you know, there might be lots of gay men who do, but I don't ... it is being managed but people don't know for how long. I mean to say it's chronic manageable, you have to see, you have to have evidence of that, and there isn't any evidence because people haven't been having the treatment for it. You know, people, the longest, what is it, ten years maybe? (Vincent: 1).

This perspective echoed those in relation to treatment optimism from the previous section, such as "... going to die", or "... eventually kill". There was also awareness that not everyone was able to take advantage of treatment:

... even more importantly, what about the people who can't tolerate the treatments. That's what really sickens me. I have friends who are allergic to almost everything they've been given and you just think, you know: 'What about those poor bastards? Where is the hope for them?' (Michael: 2).

This account expresses something of the horror of the loss of hope due to the incompleteness or intolerability of HIV medicine. These accounts suggest that we need to engage with the idea that some aspects of post-crisis rhetoric idealise treatment in a way that marginalises its failures.

However, the HIV infection experience could also be depicted in a more positive way. In the following example, the interviewee reflects on his immune system and implications for daily living:

... I talked about food [with my doctor] and I said, you know: 'With a T-cell count of four hundred and twenty and did I need to be worrying more than anyone else in the population?' And he said: 'Probably no.' I mean he said: 'Obviously things like raw egg, everyone should be a bit careful with, but on the whole,

you're really not any more at risk than most other people' (Noel: 1).

In this depiction, an interaction with a doctor was figured to show that through the effectiveness of treatment, the person with HIV was entered into the normal range of risk considerations of health and illness. It was as if for the time being, health could be 'normal' suggesting that a kind of immunological normativity informed how health was understood. Also, a question and answer device was used to depict a dialogue with a health expert. This accounting strategy had the effect of separating out the questioner (the patient) and the expert other (the doctor). In this way the narrator personalised the question about risk and living with HIV treatment. This strategy also had the effect of sourcing objective truth about risk outside the self in the expert other. This is a strategy that may have the benefit of strengthening the truthfulness of accounts of risk. It also suggests that the 'normality' of living with HIV in the post-crisis situation is contested, with implications for personal security. Discourse about it needs to be carefully fashioned so that it appears objective to promote personal security.

In another account and also using the device of reported dialogue, it was suggested that an AIDS diagnosis was reversible:

But [my physician] has used interesting language when she's spoken to me, she once said: 'You're in very good condition for somebody who has had AIDS'. There's a sense in which AIDS really described having reached a more or less irreversible stage of decline in your health. Whereas, that kind of description of what happens in the illness now doesn't seem to be very appropriate because that's not what's happening to an awful lot of people. Once you stick combination therapy into the equation people's viral loads come down and the CD4 count goes back up and therefore the word AIDS has come off and there's much more use of the term

HIV. And it just seems to be a less frightening thing in people's minds (Kevin: 1).

This account engages with the idea of 'cure'. It also suggests that AIDS no longer has the fear producing connotations of the past. Like Noel, the device of reporting the speech of the health expert lent weight to the depiction of the reconfiguration of the meaning of AIDS. It seemed that health care experts were the respected sources of knowledge about adjustments of how living with HIV and AIDS was to be understood. In this sense, health carers were positioned as the arbiters of contest about risk knowledge.

Making AIDS less visible

Another aspect of the changing understanding of AIDS was a requirement to make some aspects of illness invisible in social relations and in clinical encounters. Interviewees suggested that knowledge about the experience of HIV treatment and some of the more minor symptoms of illness had to be hidden from view to sustain social relations and to manage the competing priorities of short, clinical consultations.

Having HIV and managing treatment seemed to be an isolating experience. Robert noted: "I think friends who don't have HIV don't really understand" (2), suggesting a separation of lived experiences, a sense in which a shared ontology was not possible. Kevin noted that contrary to expectations, when he was diagnosed: "... people wanted to take a step away" (2). Interviewees also suggested that they were expected to assist others: "... and I realised that actually when you're HIV positive it isn't a case of your friends run around and help you, you have to help them cope with the fact that you're HIV positive" (Kevin: 2). Part of this process was traced into different engagements with knowledge and expertise about the experience of HIV infection: "... you know

more so you do more caring” and “... people don’t want to listen at the end of the day” (Kevin: 2). These accounts were significant because they simultaneously identified the person with HIV as a source of truth about the HIV experience, located the management of the social impact of HIV diagnosis with the patient ‘expert’ and made the uninfected separable and unknowing.

But it also seemed that the idea of the person with HIV as an expert had to be carefully managed in the post-crisis situation. It was recognised that knowledge about treatment could form part of an idealised, reflexively-made security. In this example, the interviewee expresses an awareness of the symbolic value of treatment expertise:

... as long as I have all the information about this I can make the most informed choices panders to my illusion that therefore I have some kind of control over what I feel (Kevin: 2).

In contrast, it was also possible to see oneself as an “... AIDS bore”, as too involved in the technical aspects of HIV treatment. Overdoing the expert-patient role had two rationales. One of these concerned resentment in social interaction: “I think people get angry with you for becoming HIV positive, I think they get annoyed with me for it” (Kevin: 2). The other rationale had to do with effective treatment itself. Improvements in the clinical effects of treatment could also be a reason for setting aside the need to be an ‘AIDS bore’:

I’m a bit more confident I don’t have to know everything under the sun so I kind of got fed up with HIV-oriented publications really. And I tried to minimise the kind of HIV content of my life and be as kind of normal as possible part of that is because it’s what everyone else wants and part of that is because it’s not so tiring ... (Kevin: 2).

It seemed as if the medical developments in treatment meant that one did not need extensive knowledge to establish security, suggesting a reworking of treatment expertise for the post-crisis era. One can be less of an ‘AIDS bore’ and trust in the expert systems of HIV medicine, something that conserved energy and smoothed social relations.

There was another requirement on patient expertise that proceeded out of the management of treatment. It seemed that not all issues to do with the body were reviewed in the clinic. Minor illness was dealt with in other ways. Kevin spoke of managing his own symptoms: “I’ve never bothered even telling [the doctor] about it [dry skin] because it’s very easy to manage” (1). In various ways, aspects of the HIV experience are made (or can become) invisible or hidden inside the promise of HIV treatment.

Determinacy/Indeterminacy

Treatment in post-crisis seems to be successful partly through the hidden expertise of the person with HIV and the relegation of minor ailments to ‘self-treatment’. However, the interviewees expressed that fatigue was one health concern that proved problematic in terms of required invisibility, because of its persistence, moral connotations and indeterminate aetiology. Several interviewees spoke about a lack of energy that interfered with well-being and therefore capacity for self-care. On the sheet of paper provided in the interview, Kevin wrote down a medical term noted from a consultation: “lassitude” (2). The Oxford Dictionary definition is ‘languor’ or ‘disinclination to exert oneself’. Medical dictionaries offer a straightforward definition of ‘weariness, debility or fatigue’ (Medlineplus Health Information, www2.merriam-webster.com). The difference between the English language and medical uses of the term lassitude suggests

a moral domain. Medicine in particular strips lassitude of some of its regulatory connotations, presumably to foreground objectivity. Nevertheless lassitude conveys a sense of moral laxity, something that resembles the kinds of moral judgements of the conduct of people with chronic illness in general (Galvin, 2002). Fatigue was also an issue because it was not clearly attributable to HIV treatment, HIV infection or other aspects of health such as ageing. The example of fatigue therefore reveals how HIV treatment may be organised as a 'morality of ailment'. It seemed that the business of the clinic was the objective and clinical management of the action of the virus in the bodies of patient. Ailment, such as fatigue, was a personal responsibility. Flowers has suggested that the notional project of personal well-being in the post-crisis situation is individualised and privatised (2001). This analysis extends that perspective to suggest that ~~that~~ privatisation of treatment is amplified by a moral distinction between the determinate and indeterminate aspects of the HIV treatment experience.

In the following example, the interviewee describes the difficulties of explaining the causes of fatigue. A way through this indeterminacy was to create a division between explanations that could motivate self-care and incontrovertibles that should be left alone:

Well, if I knew that it [tiredness] was the weather then there's damn all I can do about it. If I knew it was because I was getting older, there's damn all I can do about it, and if I knew it's because of my health, apart from taking the tablets which I suspect I'm quite diligent about that compared with the norm, there's damn all I can do about it. So the trick is, the only other way to attack the problem is from the other end isn't it, sleep some more then you're not so tired ...
(Stephen: 2).

This account suggests a prudent narrator making judgements about how to manage fatigue with reference to all its possible causes. In that sense the account reveals a sorting out of different explanations for fatigue and therefore the identification of a viable role for patient self-care in the management of the indeterminate. However, taking on the indeterminate as a matter of self-care may create an illusion of wellness that may not always benefit the patient:

The real problem is that everybody thinks I'm doing so well, they think I'm just the bloke to ring up and talk to about things ... I find this staggering, you know, I'm doing my best as it were, because you do don't you ... (Kevin: 2).

The separation of determinate and indeterminate explanations for ailment also helped form a kind of hierarchy of legitimate illness. Some problems were seen as "... not particularly severe" (Kevin: 2) by interviewees or by carers. In this account, the interviewee refers to advice from a carer: "... look there are plenty of people worse off than you, why don't you just live with this" (Kevin: 2). It seemed that some physical experiences and emotions were hard to make objective in the practice of HIV treatment:

They're something that I feel and only I can give evidence to. And all you've got is my oral evidence about how I feel. And since I usually look great, people don't understand why I don't feel great ... [and later] ... an awful lot of people are dealing with it on the footing that Jesus Christ: 'somebody in your position ten years ago or five years ago would have died, and you're not dead. And not only are you not dead ... actually you look great'. And so they won't kind of take it seriously because they can't objectify the symptoms, they can't see for themselves what's wrong. You sound like you're moaning. (Kevin: 2).

This account makes it seem that a public manifestation of ailment is disallowed, partly

because it is not visible and indeterminate. There is also another moral aspect to ailment. Complaining is not legitimate because other people have not been able to benefit from effective treatments. Moreover, this situation could also lead to questions over reflexivity:

... all these existentialists who write about the meaninglessness of life are actually quite right, you're in control of almost nothing in life and things will bump into you despite your best efforts (Kevin: 2).

Trust/Distrust

Another separation in the experience of HIV treatment concerned trust relations with medical experts. While HIV treatment was individualised and ailment was hidden from view, the achievement of effective viral control remained reliant on the relationship with the prescribing clinician. The interviewees suggested two main ways of articulating these necessary trust relations. One was a relatively unproblematic construction of rational self-control and a cooperative division of expertise between the patient and the health care provider. Another discourse was 'vigilance' and "... healthy distrust of the medical profession" (Michael: 2). These two discourses represent different engagements with matters of trust, expertise and security. The former rational self-control orientation is based in idealised relations of mutual respect and trust in the progressive properties of HIV medicine. The latter vigilance orientation is based on a more sceptical orientation to the manifold risky qualities of the practice of HIV medicine and therefore questions about security. I will argue that these formations of responsibility are innovations specific to post-crisis. They mirror the circulation and competition of the notions of medical ascendancy and disciplinary rule of the post-crisis context. Rational self-regulation and a sensible dispersal of responsibilities furthers medical ascendancy. Sceptical vigilance is a pragmatic adaptation to the uncertainties and irregularities of

One form of trust in HIV treatment relied on the notion of the rational patient. Stephen related how he had negotiated a change in treatment with his consultant, to reverse the fat loss to his face and arms and legs, but within acceptable limits:

Well, I'd rather take no drugs at all than continue to suffer the effects of lipodystrophy and just take a chance. Then I was told, if you don't take any drugs at all, if you want to start taking them again, you're likely to become resistant to them ... so we talked around it and various combinations were suggested, didn't pin the tail on the donkey quite, but I chose the one that was the least unattractive. Isn't that a rational, cogent thing to do? (Stephen: 1).

This account constructs a patient subject that is rational and self-determining. This form of the reflexive self is possible through a division of expertise between the patient and the doctor:

It's my job to look after myself and the doctor's job to help me do that. It's not the doctor's job to look after me. If something goes wrong with my treatment, it may not be my fault, but it's certainly my responsibility to deal with it. Now my impression is that doctors I've dealt with here regard my attitude as quite helpful, because it means I am much more receptive to the advice I'm being given. But there are a lot of people who aren't and I strongly suspect that treating HIV is difficult because people aren't rational about it ... (Stephen: 1).

Manageable HIV requires manageable patients. This is a system of medicine that valorises rationality: "Doctors treat you with respect. Doctors who treat you as if you're an intelligent person" (Stephen: 1). "Treat you with respect" takes on the meaning of a

pun in the context of HIV medicine. One is treated as if one is a responsible self-managing subject in the clinical encounter. But one is also managed through a discourse of respect that personalises treatment.

But it also seemed that this system of trust could break down. Robert reported that between interviews he moved to another clinic to find a new HIV consultant. Robert explained his action in this way:

... she misunderstood me really, because she always used to say: 'Are you drinking?' and 'Are you taking drugs regularly?' I'm sorry but you have to take that as read, because I do, you know and I told her that. It just seemed a bit sort of repetitive maybe she didn't trust me to take the drugs, you know, like she's dealing with a very young person who was a bit irresponsible. But I've only actually, I've been on these drugs since June last year and I've only actually missed two doses ... (Robert: 2).

Robert said that he needed someone: "... who's very easy to talk to and laid back and will listen to you" (2). Robert's account resembled Stephen's because it revealed an autonomous patient. But unlike Stephen, Robert's account worked to reject infantilising on the part of his carer. Robert's depiction of his experience of HIV medicine raised the prospect that trust is bi-directional. The theory of risk society implies that trust is central to the reflexivity of the individual with abstract systems. Following this view the patient places trust in HIV treatment. But to overly question the self-management capacities of the patient reveals a lack of trust on the part of the carer. Not only is trust in abstract systems a requirement of reflexive operations on the self, the autonomous subject needs to be trusted as a matter of care. In this perspective, trust has a distinctly relational quality. Stephen depicted his experience of medicine as a fairly unproblematic exchange

of “respect”, suggesting that the clinical encounter could be egalitarian. In contrast, at one point Michael suggested that he had a: “...healthy distrust of the medical profession” (2), an elaboration of trust relations into a sense of savvy negotiation of the clinical encounter. It seemed that in relation to HIV medicine at least, trust works in both directions and with different emphases.

Responsible/Irresponsible

The responsible action of the patient was another key theme of accounts of HIV treatment. In keeping with the privatisation of the HIV experience, there was a personalised quality to accounts of treatment uptake and choices: “... I do regard myself as primarily responsible for my care” (Kevin: 2). Responsibility could be constructed as “empowering” a way through insecurity:

So February ‘90 with the first positive result: defeatist attitude, self pity, until October ‘92 when I got my first feelings of hope, empowerment, and sense of personal responsibility. A freedom that was the main result of it. Suddenly feeling that I was free from all of that negativity ... (Michael: 2).

In this example, “hope” and a sense of personal control was connected with the adoption of “personal responsibility”. But responsibility could also be too much of a challenge. In the following example, the interviewee makes reference to a decision about commencing HIV treatment:

... they [doctors] would say well, there are advantages and there are disadvantages and it really is your decision ... I got from the doctor and the ATP [AIDS Treatment Project], they said well it really is your decision, well I thought: ‘I’m not medically qualified’ (Malcolm: 1).

This account foregrounds the post-crisis form of responsabilisation of the patient. Taking treatment is a patient responsibility. But the technical knowledge that helps constitute effective treatment is found elsewhere. The technical was not the province of the narrator, but the choice of whether or not to make oneself available to treatment did seem to be a personal responsibility. Malcolm's protest: "I'm not medically qualified", was a way of signalling that it was not an easy thing to engage with the uncertainties entailed in the decision to embark on treatment, partly because expertise was located outside the self.

But treatment responsibilities were also moral responsibilities. For example, treatment responsabilisation flowed into judgements about people who had mismanaged their treatment choices. Colin spoke of a friend in this way:

... and he then blew his first combination by overworking, not taking his pills at the right time, the virus bounced back. So now he's on a really bad regime, he's on the liquid Ritonavir [treatment] for the last year and he hates it (Colin: 1).

Colin's friend is made out to seem as if he had squandered his treatment options, failing to take personal responsibility and also failing to secure effective engagements with treatment expertise. For this reason, a sub-optimal treatment was therefore one's own fault. This sense of 'you make your bed, you lie in it' was related to delayed HIV testing:

... if he had gone to the doctor, and got a test two years prior to that he could have watched his CD4 fall to a reasonable level and then started taking combination therapy. I mean like six months before I found out I was HIV, combination started coming out so he could have, he could be in a better situation than he is now if he hadn't, if he had faced the truth ... (Colin: 1).

This account implied a judgement on the risk management practices of a friend. The use of "... the truth" also suggested that there was a correct way of engaging with HIV treatment and that failure to do so was an indictment of character. In this way, a certain form of engagement with HIV treatment expertise had the status of a regime of responsible, moral self-care. Ronald also created an account that referred to a responsible self, planning for a future with treatment: "... I'm trying to make it last longer before I have to use those drugs. Because I don't want to use them now and then they stop working" (1). The prudent management of time was therefore also a key aspect of treatment expertise. The account also makes a connection between treatment responsibilities and sexual conduct that emphasises the maximisation of the future effectiveness of treatment:

... it's really sad, from my point of view, they think because now we've got really good drugs they're going to play with that. For me it's so ignorant ... the people that are advertising on the Internet for better sex. If that's what they want to have, fantastic, go ahead and do it. Do with your life what you want, enjoy it as you like. I'll make sure I get my life on the decent path. Everyone's got a different way of seeing things and I just think being that way is not caring much ... I'm going to stay looking after myself ... (Ronald: 1).

This account refers to the chance of reinfection with drug-resistant virus in sex between HIV positive gay men. The account underlines the moral aspects of self-management by replaying the story of irresponsible sexual practice and the Internet discussed in chapter three. But the account also signals that risk management is a matter of personal choice. And through the idea of reinfection, sexual practice is sutured into responsible treatment management, reflecting the significance of the links between treatment and sexual conduct in post-crisis discourse. These perspectives on responsibility suggest that HIV

treatment is associated with an intensification of moral judgements about self-management in terms of both treatment and sexual practice.

Private insecurity/Public complacency

As I have suggested, these interviewees construct a post-crisis situation that is provisional and where there is focus on a kind of personalised management of HIV treatment. This personalised management is achieved by making AIDS and HIV less visible. Moreover, trust relations and personal responsibility are also a focus for the self. However, there was also a sense that accounts of the risk meanings of AIDS and HIV referred to several identities. These were a generalised public other, the medical expert and the gay man with HIV themselves. These different identities of the post-crisis situation suggest the circulation and contest of expertise and objective truth about just what HIV and AIDS now represent. Importantly, from the point of view of gay men with HIV, the risk considerations of HIV infection endure, while AIDS has a changed and perhaps reducing importance in both private and public representations of the epidemic with significant implications for HIV prevention.

The interviewees suggested that the HIV epidemic is not what it was. In this example, the notion of dying with AIDS is seen as a cliché that connotes a complacent public:

I don't see anything in advertising anywhere nothing on television even the stories of somebody dying of HIV or AIDS in a soaps now has all gone a bit too dull for producers, for TV programmes. They are sort of wiped out now. You've got that whole cliché of somebody dying of AIDS ... which is a bit sad really considering how it changed the world when it first came out (Edgar: 2)

As if to underscore the privatised quality of the HIV experience, there were many

phrases used to describe complacency about the HIV epidemic on the part of others:

... a lot of gay people have forgotten about the HIV issue ... (Edgar: 1),

... at first there's all this sort of big fuss and whatnot, but when all that dies down, everyone just gets on with their lives ... (Rodney: 1),

... I think combination therapy, to some people, has been seen as a panacea ... (William: 1),

... people think rightly or wrongly that it's no longer a death threat ... (Tony: 1).

These phrases suggest that post-crisis complacency is an attitude of other people. In addition, the situation for people with HIV was not intelligible through this discourse of post-crisis complacency:

People don't seem to understand, maybe there's a kind of headline mentality or spin-doctor mentality here. They seem to think that combination therapy represents some kind of cure. Well they don't understand that combination therapies fail. They can have very damaging side effects. They're a complete bloody nuisance in your life. And they don't reverse all the effects of having been infected by HIV There are loads of consequences attached to being HIV positive even if one of them is no longer dying in agony in two years' time. So I think it's terribly important that all those things be brought home to people. And of course you've got the whole kind of mental thing of knowing that you are chronically ill, chronically infected with the virus. That it's irreversible and that it fucks up your sex life. If that can be brought home to people perhaps they'd still be a bit more careful now (Kevin: 1).

Kevin's account signalled a dissonance between personal experience and public representations of HIV risk. There was a sense in which the HIV experience had passed out of public view, and was experienced as a more personal, hidden engagement with health and social risks of various kinds.

In this situation of public complacency and private insecurity, HIV prevention had contestable meanings:

I don't know, depends what your attitude is to HIV. I mean, depends whether you regard it as life threatening or if it's just another of the many diseases around which, you know, there are a number of drugs which sort of deal with it even if they don't cure it. Depends what your attitude is ... ultimately whether you think there's going to be a cure around the corner. I suspect in everyone's mind there is this idea that there's a cure around the corner and that you can basically screw around and not really worry about it ... (Tony: 1).

The key concept here was the contested assumption about the life-threatening status of HIV infection. Tony showed that the meaning of HIV was in flux and that there were multiple views on how it compared with other illnesses. In a sense, HIV, through effective treatment, was subject to 'normalisation' but also to 'multiplication' of approaches to risk:

I think a lot of the people think they might be going to get it, HIV or AIDS. I think there's a danger element. I think there's a macho element. I think people get too high on drugs. I think the condom splits and people can't be bothered. People are whacked out a lot of the time ... I think some people are irresponsible. I think the world's made up of different people, you know, there's no hard and fast rule for everybody ... (Peter: 1).

The use of “... there’s no hard and fast rule for everybody” suggested an intensification of the importance of personal choice in risk management. It seems that questions of personal choice are amplified from the point of view of gay men with HIV in the situation of public complacency and private insecurity. When asked about the approach that prevention could take in the context of these post-crisis meanings, Adam expressed a sense of limitation:

I think the prevention bit is impossible really you're never going to stop the people that know there is a risk, but prefer to take that risk. And I think it's quite a big majority of people. As long as the information is there for the younger ones that are not going to be taken advantage of, then that's fine ... (Adam: 1).

In this account risk management was a matter of privatised volition. As long as people had “information” that lessened their vulnerability, it was up to them how they conducted themselves. Colin suggested that a friend of his found that safer sex was not relevant:

Well, XX's attitude last year, well: ‘If I become positive, I'll just pop some pills’ and I assume, maybe wrongly, that that's the reason why these kids are jumping off and on people's cocks, because they just like shoving a finger up to bureaucracy and saying: ‘Fuck your safe sex programmes. We've now got drugs anyway. Why the fuck should we believe this any more?’ (Colin: 1).

These accounts were marked by a division of self and other, where the narrator was positioned as the reporter of the behaviours and opinions of others. They do signal that new meanings are able to be attached to prevention such as “... more prepared to fuck in an unprotected way”, “... you're never going to stop the people that know there is a risk but prefer to take that risk”, “... fuck your safe sex programmes”. In these accounts,

safer sex is positioned as a form of resistible governance, a programmatic obstruction of the 'freedom' of the individual, a meaning of risk that was discussed in chapter three in relation to barebacking. There is a suggestion that there has been a shift from safer sex as a collective response to risk into a situation where individual choices have more importance. This re-shaping of risk management suggests that responses to risk in the post-crisis era are not only to do with the advent of treatable HIV. There are also questions about how HIV prevention articulates with the ways that health citizenship is conceptualised in general.

Summary

This chapter has established a depiction of the post-crisis experience grounded in the personal accounts of gay men with HIV. This depiction questions the notion of a net 'optimism' in personal assessments of the effectiveness of treatment. Instead the interviewees constructed themselves as aware of both the benefits and drawbacks of treatment. In place of easy treatment optimism, the interviewees were focused on personal methods of self-care fashioned to extract positive value from the uncertainties of the post-crisis situation. In addition, treating and preventing HIV in post-crisis was framed by the inter-dependent notions of public complacency and private insecurity. This private/public separation is connected with challenges for self-management such as the indeterminate qualities of wellbeing, the valorisation of both orthodox, medicalised rationality and sceptical vigilance, the nuances of trust relations, and moral judgements of the self-care capacities of individuals. Moreover, it is through these kinds of reflexive practices on the part of gay men with HIV that the changed visibilities of both HIV and AIDS are achieved, lending support to the idea of reflexive treatment developed in chapter three.

... If that's what you're doing [unsafe sex], keep it to yourself, you know. It's your life, you do as you please with it, you know, if you want to kill yourself, fine ... I won't be made to feel as though it's my problem when it's their actual doing, you know. 'Coz we all have choices in life. So if they choose to do that, it's their choice, not mine ... (George: 1)

Introduction

The previous chapter suggested the shift in meanings of both HIV and AIDS articulated with a public/private division. It also identified some of the implications for the relationship between treatment and prevention connected with public complacency and private insecurity. This chapter extends the exploration of the relationship between treatment and prevention in connection with the construction of identity in the personal experience accounts. I will argue that, in the post-crisis situation, treatment and prevention have differing rationalities and implications for identity. In general terms, the treated self is understood as mutable and open to innovations pertaining to HIV treatment. The self of HIV prevention is subject to universalising imperatives. Reflexivity about treatment appears to be open to the social and biological meanings of HIV infection and the multiplication of virus associated with the advent of treatable HIV. In contrast, HIV prevention is concerned with responsibility and concerns the ethical management of the social and viral risks of HIV, in part predicated on the avoidance and resistance of blame. This chapter therefore explores the mingling of two disciplinary requirements: how "... one must become a doctor of oneself" (Foucault, 1988: 31) and the ethical self-contemplation implied in the imperative of a "... certain complete achievement of life" (Foucault, 1988: 31). In the first parts of this chapter, I

address accounts of treating the self and forms of risk metaphor that enable self-care and risk management with reference to the mutability of HIV. Then I consider how the interviewees accounted for the HIV prevention imperatives of the post-crisis situation. In the last part of the chapter, I reflect on how the interviewees attempted to resolve the complexities of innovation and imperative in their sexual relations.

The treating self

This section concerns HIV treatment and identity. My interests include the ways that interviewees constructed selves that could be ‘observed’ via the discourse of treatment. In the context of a discussion of science as a cultural practice, Baudrillard used the idea of space exploration and the capacity to literally gaze on planet earth as a metaphor for how technology is used as a way of looking at oneself, a method of self-satellisation (Baudrillard, 1994: 34). The ways in which the interviewees accounted for their bodies, health and HIV infection revealed selves with HIV satellised via psychological and medical perspectives on treatment. But this self-satellisation was not simply domination by psychological and medical frameworks of treatment. Psycho-medicalisation of self provided the basis for self-management and was also open to the provisional character of the knowledge systems that inform the practice of treatment.

Chapter five identified the sense in which the interviewees internalised a responsibility for their own health, for example: “I do regard myself as primarily responsible for my care” (Kevin: 2) and “... responsible for your whole life again” (Michael: 2). These responsibilities translated into forms of self-management: “... you sort of make adjustments to your lifestyle get fit exercise look after yourself, eat sensibly, try and avoid stress” (Robert: 1). The interviews also revealed a division of expertise between the patient and the physician: “It’s not the doctor’s job to look after

me. If something goes wrong with my treatment, it may not be my fault. but it's certainly my responsibility to deal with it" (Stephen: 1). However, the interviews also revealed a separation of self with HIV and the observing self. Self-care was depicted through the device of separate identities in accounting practices: a self as narrator and the self with HIV. For example, in the next example the interview reflects on a period of ill-health:

I wasn't feeling well. I was feeling quite pathetic. And I was feeling really sorry for myself at the same time: physically watching myself go down the drain. I used to be well built. I used to go in the gym all the time (Andrew: 1).

Andrew employed a metaphor of waste to depict changes in his body. His account also achieves a separation of the objectified self for the observing self. Both body and mind were observed for changes related to HIV infection. Likewise, the effects of treatment were also open to self-observation. In the next example, the interviewee discusses explanations for fatigue and the use of HIV treatment:

I think it must be related to HIV. I talked to my doctor about it and he said: 'Well there are two things. The first is that the virus is probably still in your body and therefore your body is dealing with the virus and it's taking a certain amount of energy to do that. And that must in itself, since you're constantly ill, that must in effect, be tiring. Secondly your body is having to process very toxic drugs in order to help it deal with the virus. And the actual process of expelling the drugs, which is the first thing your body tries to do isn't it, it tries to get rid of these things you take, that also is something that's tiring' (Kevin: 2).

Kevin adopted the speaking position of the doctor to relay explanations concerning the physical experience of fatigue. Taking the position of the observing expert is a way of

narrating self-satellisation. These examples reveal interviewees caring for themselves using the observational modes of medicine. Writing about the illness experience, Good has suggested that medical objectification has value for reflexivity:

Many medical activities, as well as traditional forms of healing, can be seen as devoted in part to objectification and reconstituting of the threatened lifeworld as efforts to counter the unmaking of the lifeworld. Diagnosis is an effort to depict the source of disease, to localise and objectify cause (1996: 128).

It is my argument then that such self-objectification on the part of interviewees has ontological value for establishing reflexive treatment. The ontological qualities of objectification also connect with the concerns about ontological health related to the uncertainties of treatment that appear in the HIV illness narrative literature discussed in chapter two. There is also a resonance with uncertainty and therefore the risk society notion of ontological security discussed in chapter five in relation to post-crisis futures. Self-objectification through the knowledge systems of HIV treatment provides a way of grounding the self. The following account supports this notion of the value of self-objectification:

I become grim. Sometimes I cry. I get maudlin. I tend to think a lot of other negative things, I can see there's something and I stop it. I can't explain quite how I stop it because this resulted from being in therapy for about three years. I have acquired some kind of subconscious technique, and it's only visible manifestation I can see is that I'm aware that at some point we're slipping into depression, let's just stop this for the moment, let's go and do something easily achievable, like the ironing or tidy your bedroom or go away for the weekend or whatever. And then I'll set myself one of those easily achievable targets and I'll do it, and that will

begin to restore my kind of psychic balance as it were. Or psychological balances perhaps ... (Kevin: 2).

“We’re slipping into depression” suggests two identities in self-care, the sick subject and the narrating, self-administrating subject. “I’ll set myself on one of those easily achievable targets ...” suggested self-management. “Watching myself”, “... your body is dealing with the virus” and “...we’re slipping” suggest the vantage point of the observer. And such ‘observations’ are elaborated in the technical language of the various expert systems of self-care that support HIV treatment such as psychology and medicine. The depiction of self-management is also suggestive of Rose’s argument about the role of the psy- disciplines in care of the self (1989). The example also indicates that interviewees were aware of the incomplete and provisional qualities of the knowledge systems of treatment. “Subconscious”, “... psychic balance” and “... psychological balances” perhaps refer to cognitive behaviour modification and psychodynamic theory. Also, Kevin’s vision of his emotional trouble was specified through a mixing of psychodynamics, behaviourism and systems theory, something that suggested an awareness of the contestable quality of these perspectives on care of the mind. The psychodynamic “... psychic balance” was revised into the more behavioural “... psychological balances”. “As it were” seemed to suggest an awareness that there was theoretical contention between psychodynamic and cognitive behaviour modification about how to best operate on one’s mental health. These kinds of awareness suggested that the self-caring patient was also reflexive with the perturbations of systems of expert knowledge, suggesting a manufactured uncertainty for the domain of the care of the mind. It was as if reflexive treatment, necessarily opened to the competing psychological frameworks of care, provided a revisable means of self-governance. The correct management of self is therefore always in flux since

there is the possibility of a better method, or new combinations of old ones.

Treatment innovation and metaphor

Building on the idea of the relationship between self-observation and reflexivity, I want to suggest that metaphorical language about self with HIV may provide for an indeterminacy that is useful to interviewees. Metaphors of self with HIV gesture towards the social and biological meanings of HIV. As such, they parallel debate in sociology about theory of the body to do with the articulation of social constructionism and foundationalism, between the body as an effect of discourse and the social effects of the material parameters of a corporeal body (Prout, 2000). In the first part of this discussion, I suggest how metaphor appears to provide a way of engaging with the unsettled quality of how the social and material experience of the body is understood and in that regard opens reflexivity to mutability. In the second part of this discussion, I outline how metaphor also provides a method of encountering both the uncertainties and the innovations connected with the advent of treatable HIV that are relevant to prevention.

Metaphor for managing the self with HIV

Some interviewees referred to themselves or other people with HIV using what appeared to be abbreviations such as 'I am HIV' or 'He is HIV'. In particular, both metonymy and synecdoche appeared to have significance (Cameron, 2001). The distinction between metonymy and synecdoche has relevance for discourse about the self with HIV. A metonym is a figure of speech where an associated is used to signify a person. Synecdoche is a figure of speech where *part* of the person is used to signify them. In the next example the interview reflects on risky sex with his HIV negative partner and HIV transmission:

Edgar: This morning, I don't know or whether he sort of believes enough in his mind that we will always be together so it wouldn't really matter if he becomes HIV anyway 'coz he wants to share that with me. I don't know. I don't know whether he thinks in his heart that he loves me so much that if he became HIV, it wouldn't really matter to him you know

[and later]

Edgar: Him becoming HIV through me (2).

“Becomes HIV”, “... became HIV” and “... becoming HIV” appear to be forms of speech that shorten constructions such as ‘he could become infected with HIV’. ‘I am HIV’ is evident in discourse in the HIV field and represents a contraction of the self-ascribed medical label ‘HIV positive’.

However, “... becoming HIV” has a double metaphorical quality to do with metonymy and synecdoche. HIV works by integrating itself into host cells in the bodies of people with HIV (NAM, 1998a). These cells are used to produce more HIV, a function that ultimately destroys the host cell. HIV appears to favour the use of key cells in the immune system. Over time, the destruction of these immune system cells creates the conditions for life-threatening infections and malignancies. “Becoming HIV” can be synecdoche for HIV as part of the self. However, HIV diagnosis is also a social process of identity formation (Lather, 1995). “Becoming HIV” can be taken to be metonymy for a loose connection between HIV infection and self-identity, a labelling of the self rather than something in the individual. Metaphorical language about self with HIV therefore has the property of enabling reflexivity about both the biological and identity-related aspects of HIV infection.

It also seemed that metaphor could be adapted to some of the innovative qualities of effective HIV treatment. In particular, metaphors were used to mobilise the idea of variable virus implied in concepts such as viral load and infectiousness or reinfection and drug-resistant virus. In this regard, metaphorical constructions of self with HIV were also mingled with the imperative of HIV prevention. Such constructions link the self, medical techniques for the identification of risk and conduct. They therefore suggest the extension of disciplinary rule through treatment, as in the work of others discussed in chapter three (Adkins, 2002; Heaphy, 1996; Race, 2001). But these metaphors also have an effect of multiplying selves: a self as the biomedical HIV object; a self as manipulated through treatment; self as a risk to others; and a narrating/observing self. They represent a kind of appropriation of HIV treatment in lived experience, or in other terms, an engagement with innovations in biological and social meanings connected with the post-crisis situation.

The idea of viral load and infectiousness was rendered through metaphor about identity. In this example, the interviewee refers to the idea of “... undetectable”, which is the name given to a measure of viral load that signifies optimal viral suppression and therefore effective treatment (AIDSmap, 2003):

MD: So you saw yourself as more infectious in that period

Michael: Yes, yes

MD: ...because of the viral load?

Michael: Yes. Because of the viral load. Because I know that just because I'm undetectable it doesn't mean that there isn't HIV in my blood and that I'm not infectious ... (2).

“I’m undetectable ... ” is a straightforward extension of the metaphorical contraction of the person as HIV to a statement about viral load results and risk management. In this example, the person with HIV positions themselves as both the narrator and as ‘undetectable’. The label of low viral load is therefore applied to the self. “I’m undetectable ...” serves similar purposes to “becoming HIV ...” as it summarises social and biological processes, in this case, in terms of medical knowledge derived from blood testing. Metaphorical constructions of AIDS have been traditionally formulated to mark the other as a source of contagion (Sontag, 1988; Treichler, 1988). In “I’m undetectable ... ” the source of contagion is also the self, bringing HIV transmission and therefore prevention into self-objectification. There were other variations of this self-applied metaphorical language of HIV risk and biomedical technology:

MD: But your viral load, what is that like?

William: Undetectable

MD: So how does that make you think about oral sex?

William: It doesn’t make me think that I’m any less infectious

MD: Really

William: I still think I’m infectious as I was when I had millions of a viral count of millions

MD: You still feel as infectious?

William: I feel as if I am (2).

Compared with Michael, William used a different phrase and had a different opinion about the risk implications of infectiousness and viral load. But “I’m undetectable” and “I’m infectious” were both views on the risk potential of the self. In this form of self-objectification, the self becomes a source of risk, instead of risk being derived through assumptions applied to measures of the amount of virus within the body revealed by

blood tests. Stephen used a similar construction:

Stephen: Now I gather viral load is also a measure of infectivity I believe they're related. And it doesn't mean oh goody goody, I can take more risks. It just means I believe they're related, which is quite a comforting thought. So if it's lower then I'm less likely to infect somebody (2).

"I'm less likely to infect somebody" serves the purpose of summarising treatment effects and the risk of transmission of HIV. "Less likely to infect somebody" refers to a biological process where treatment reduces viral load so that, arguably, transmission may be less likely to occur. However, the self is located as the HIV object that, through treatment, is rendered less dangerous. The mingling of treatment and prevention in identity metaphors suggests that innovation and imperative are taken into self-construction.

The idea of reinfection and drug-resistant virus was also open to metaphor. In the next example the risk implications of reinfection are depicted with a metaphor that is also a pun:

Edgar: Yeah coz we discussed this the first time I saw you that whole bareback riding thing

MD: Yeah

Edgar: You know it's such a big chance to take that you could be well like I've been and then get, you know, shagged by another virus and then become really quite ill you know coz that virus could be completely different to the one you've got which you probably would be coz they all are anyway more or less aren't they ... (2).

“Shagged by another virus” was used to describe the situation of reinfection where the HIV positive person can be infected by a virus of another genotype that is resistant to HIV treatment (Pozniak et al., 2001). Here, instead of being “shagged” by another man, Edgar is “shagged” by another virus, giving rise to the idea of a virus with sexual properties. The metaphor therefore is something of a pun in two ways: the idea of a ‘shagging virus’; and the idea that Edgar and his sexual partner are viruses. Robert used the term “... fatal injection” to refer to unsafe sex:

I mean you know you could be giving them a fatal injection really, let's face it, that's what it boils down to I just think psychologically I couldn't, I probably couldn't get it up knowing that they're negative and I'm positive and they want me to fuck them without a condom (Robert: 1).

“Fatal injection” was a kind of dark joke or pun. Other quotations mix identity, medical technology and the virus. In this example, the interviewee refers to a decision to have sex without condoms with a HIV positive partner:

... he didn't see the need to have protected sex. I could see his point, but I was in two minds. So I consulted my doctor and he said: ‘I really wouldn't worry about using condoms’. He said that I had a very low level of HIV so I probably wouldn't reinfect him with that. It seemed apparent we had the same strain. He said the one thing I could cause was drug resistance. I could make him resistant to the drugs I'm on (Robert: 2).

“I could make him resistant” is a slippage of self with HIV and the risk of drug resistance. Here the other person becomes resistant, rather than infected with drug-resistant HIV. The account also uses reported speech to convey technical knowledge. In this way, the account suggests the presence of the medical expert and their observing

position in risk narrative. The account is therefore somewhat of a pastiche of post-crisis identities: the narrating self; the self as HIV; and the medical expert. Returning to a previous example, here the interviewee also uses reported speech to underline the medicalised perspective on treatment side effects:

Well, I'd rather take no drugs at all than continue to suffer the effects of lipodystrophy and just take a chance. Then I was told: 'If you don't take any drugs at all, if you want to start taking them again, you're likely to become resistant to them' (Stephen: 1).

In this account, the drug-resistant self is constructed through the reported speech of the medical expert. Like the metaphors of self as HIV, these 'jokes' and word-play had the effect of linking the technological language of medicine with self-construction, and linking the self as virus with the notion of risk for the other. These accounts therefore suggest how post-crisis meanings about treatment and HIV prevention are taken into identity. They signal disciplinary rule but one that permits the transformations of self connected with the innovations in effective HIV treatment that have implications for HIV prevention.

Post-crisis prevention imperatives

"Shagged by another virus" and other post-crisis risk metaphors help to establish a connection between treatment-related understandings of viral manipulation and the imperative of HIV prevention. But metaphors such as these make it seem that treatment and prevention are easily combined. In this section, I want to argue that the mutable quality of treatment-related self-understanding contrasted with the imperative quality of HIV prevention discourse. This analysis is achieved with reference to the HIV prevention advertisement introduced in the re-interviews as a way of exploring

prevention meanings and discourse (Appendix Two). First, I discuss how the advertisement formed a kind of mirror for the interviewees and therefore encouraged forms of ethical self-contemplation connected with the disciplinary rule of the post-crisis situation. I then discuss how the interviewees engaged with the imperative of HIV prevention.

Seeing the self in prevention

In the last section, I argued that self-treatment relies on self-satellisation and is opened to the mutability of HIV in post-crisis. However, HIV prevention appears to rely on a different emphasis in the optical logic of self-surveillance, one of reflection. As noted in chapter three, Foucault argued that care of the self implied a certain form of self-surveillance: “The soul cannot know itself except by looking at itself in a similar element, a mirror” and “In this divine contemplation, the soul will be able to discover rules to serve as a basis for just behaviour and political action” (Foucault, 1988: 25). The HIV prevention imperative appears to mobilise contemplation of the responsibilities of an ideal self with HIV. It assumes a universalised actor and implies responsible action. But, it also seems that the HIV imperative transports blame for HIV transmission.

The HIV prevention advertisement itself addressed how mistaken assumptions can lead to risky sex. In particular, the advertisement relied on a generalised notion that some gay men assume that their sexual partners have the same serostatus, that is: the notional negative person assumes that their sexual partner is also negative; the notional HIV positive person assumes that their partner is HIV positive. In terms of HIV prevention, both assumptions may lead to the lack of use of condoms because risk of HIV transmission is seen as, respectively, impossible or of minimal health consequences.

HIV transmission risk therefore arises when mistaken assumptions lead to the chance of the lack of use of condoms in sex between a HIV positive and HIV negative man. The advertisement engages with the serological construction of risk management discussed in chapter two in connection with negotiated safety and other forms of reflexivity about treatment and related medical technologies such as the HIV anti-body blood test. The advertisement also provides an example of the kinds of HIV prevention interventions discussed in chapter three figured around responsible action on the part of people who know they have HIV. The technique of the advertisement relied on an assumption of readers as individuals whose conduct was risk averse and where the risk relationship was constituted as a matter of instrumental, epidemiological rationality. Conversely, discussion of the advertisement revealed that it was interpreted primarily as a message about the HIV prevention responsibilities of the gay man with HIV. The advertisement itself was indeterminate in various ways, for example: blurry figures; global audience; the overall message of 'assume nothing'. However, the blurry advertisement was nevertheless interpreted to convey the imperative of responsible conduct on the part of gay men with HIV, suggesting the constitutive power of self-surveillance in the presence of minimal social cues.

Superficially, the advertisement was seen as deficient. It was depicted as not relevant because it did not stand out and because its message was unclear:

MD: What do you think about it? What does it say for you?

Andrew: It says absolutely nothing to me

MD: Oh why?

Andrew: Cause I've seen many of them

MD: Yeah

Andrew: If it said one in three men are positive it might stand out a bit more (2).

There was also a sense that the advertisement addressed a readership unlike the interviewees:

Well, look, here's two really cute young boys, nice tee shirts and all this, I mean this doesn't seem to relate to me at all, you know, this doesn't look like an encounter I'm going to have. And 'assume nothing'. 'It's your shout'. I mean it's your shout, go on tell him, go on. Is it really your shout? I'm not really making sense of these few lines here (Kevin: 2).

This account suggests that the advertisement was found to address other gay men. And its language was open to challenge. It was deemed too "subtle":

Thomas: ... if someone doesn't want to use a condom you can't assume that's because they're assuming you're both positive and you can't assume that he's thinking you're both negative and the message is, it's your shout, it's your decision.

MD: So do you agree with that?

Thomas: Yes I do. I'm not sure I think it's quite, it's maybe too subtle for maybe getting across the message (2).

Thomas's account revealed that the message was comprehended, but only just. "Wishy washy" was another description:

... that's not going to say enough to someone who's positive and just thinks well it doesn't really matter, because if he's positive as well then that's fine. It's also the thing about, where's your responsibility, in case they're not [positive], because it is about personal responsibility and you're responsible whether you're negative or positive. So I think it's too wishy washy (Michael: 2).

There was a sense that the advertisement was produced in a way that ran counter to the experience of the interviewees and that it did not make the point strongly enough or seemed to miss the point. The advertisement was also interpreted to reflect a normative understanding of same serostatus sex without condoms, for example:

... it is when you first sort of look at it because you've got 'no-one mentioned condoms I assume he must have HIV too', 'I assume he must have HIV too'. Obviously if two people aren't going to discuss condoms then I don't really think that either should assume that you are going to be HIV positive and the other one's going to be HIV positive, 'coz I certainly wouldn't fuck with somebody if I knew they were HIV positive (Edgar: 2).

This interpretation signalled that discourse about HIV prevention was framed by assumptions of particular forms of risk practice, in the case of this advertisement, unsafe sex between same serostatus men (– to – and + to +). The advertisement made sex without condoms between men with HIV seem normative, something that was nonsensical to some. Some interviewees were bemused that assumptions were possible at all:

If someone is negative and they assume the other person is negative. What? Oh God ... it's like open your eyes. We all do look healthy. We don't have to look ill to be positive. I have had that judgement in my time: 'Oh God. He looks really ill' (Andrew: 2).

Andrew expressed surprise that the advertisement was needed, because people should know that people with HIV may not appear ill, particularly in post-crisis. However, his account admits that people do judge others according to their appearance.

These interpretations of the meaning of the advertisement suggest the relationship between hermeneutics and identity. The meanings of risk are framed by the social identity of the interpreter, how they engage with HIV risk and how they understand the post-crisis situation. Further, not all HIV positive men have the same beliefs about same serostatus sex, and not all readers have the same relations with knowledge about risk. There is therefore a separation between the universal intentions of the advertisement and the particularities of interpretive positions. This separation is suggestive of asymmetry in the relations of agency and domination in the perspectives of governmentality, or the “... aesthetics of existence” noted in chapter three (Burchell, 1993: 268). Interpreting the advertisement can be regarded as a ‘hermeneutics of self’ because one’s interpretation reveals or expresses the self in terms of a kind of aesthetics of risk. The advertisement therefore, is seen to have explicit and implicit disciplinary qualities in terms of HIV prevention but also in terms of the production of certain risk styles or positions.

The ‘should’ of prevention

However, despite the “... wishy washy” quality of the advertisement and its multiple readings, a message was discernable regarding correct conduct on the part of gay men with HIV and through it, a related imputation of blame. This judgement of blame suggested another way that treatment and prevention are combined in the post-crisis situation. As I discussed in chapter five, among other forms, post-crisis was connected with turnaround narrative:

I resigned myself to the fact seven years is what I've got and that's what I was working at. And then fucking eight years came along, then nine and ten: “What the fuck's going on here?” (George: 2).

Prior to the advent of effective treatment, AIDS signified death: "... in 1991 it was HIV equals AIDS equals death" (Michael: 2). In the crisis period, living with HIV was articulated in various ways and to varying degree with the idea of victim (Sontag, 1988). Victim status in health discourse implies a kind of suspension of responsibilities, as suggested by Parsons's notion of the 'sick role' (Frank, 1991). But post-crisis discourse appears to dissolve the sick role qualities of the identity of someone with HIV. It seems that in the era of improved treatment and extended life, victimhood and the suspension of responsibilities has given way to duty and blame. It can be argued that the idea of post-crisis enables a shift from the suspension of blame connected with the 'sick role' to responsabilisation of the individual in connection with the putative chronic disease status of HIV infection. The rise of blaming also resonates with Douglas's comments about risk culture and the moral distinction between being "... at risk" (innocent) and "... in sin" (the source of infection) (Douglas, 1992: 28). The post-crisis combination of the risk management potentials of HIV treatment and the imperatives of prevention has a negative effect in that it enlivens the blaming of individuals with HIV infection (Castel, 1991).

The blaming aspects of the imperative of HIV prevention were revealed in constructions that centred on "should" connected with interpretations of the advertisement:

... because one should assume nothing (Stephen: 2),

... if no-one's mentioned condoms they should be used (Paul: 2),

... okay it's your shout do you buy a drink or not or is it your shout you tell me something I should know (Andrew: 2).

... somebody should have mentioned condoms (Kevin: 2).

In these examples, the advertisement was seen to depict lack of compliance with prevention advice on the part of the two figures. The advertisement was seen as a way of encouraging the reader to think about what one “should” do, to provide a kind of vicarious educational experience for a fallible readership. In this way the readers were asked to internalise a mode of conduct for gay men that one “should” act in a certain way. Importantly, “should” was ‘read in’ without it having to be put into typeface (see Appendix Two). The advertisement was therefore able to invoke a standard of practice without spelling it out. That the readers were able to do this interpretive work suggested the circulation of standards of ethical conduct in HIV prevention. The advertisement therefore symbolised a kind of universal imperative of risk responsibility on the part of gay men with HIV. In chapter three, I outlined how the encouragement of altruism on the part of gay men with HIV has become a feature of HIV prevention since the advent of treatable HIV, sometimes taking on the tenor of controversy (Miller et al., 2000; Schiltz & Sandfort, 2000; Sheon & Plant, 2000). Analysts have proposed that HIV prevention, especially in the context of increased survival, needs to establish and promote the altruism of people with HIV (Friedman, 1994; King-Spooner, 1999; Kok, 1999). The interventions that arise from this standpoint centre on an “... acceptance of responsibility for not infecting others [which] can serve as a relevant motivator” (Kok, 1999: 245). Such interventions are designed to assist people to “... increase the influence of a person’s pre-existing ethical motivations on his or her behaviour. [and] not to preach or moralise” (King-Spooner, 1999: 144). Statements like these have the appearance of tautology given the present analysis. It seems that the altruistic imperative is inevitably moralising. Moreover, responsibility may not require the force

of encouragement, since it is a mode of self-governance.

It also seems that HIV prevention may need to attend to the blaming that is conveyed in the articulation of responsibility. For example, through apportioning blame, the advertisement was seen to make sex into something that was abnormal:

Those three sentences only make sense on the footing that one of these boys was HIV positive, the other one wasn't, and that one has infected the other. And, you know, I have problems with it being put that way because it sounds like, you know, somebody was at fault, very silly, done something ... [I am] sick and tired of blame being adherent in some kind of sexual moment. Everybody's having sex all the time for fuck's sake, you know, it's only a normal thing which people do ... (Kevin: 2).

Kevin's expression of resentment signalled a struggle with the internalisation and rejection of blame and guilt. Neither of these meanings were actually stated in the advertisement. But the moral qualities of the prevention imperative for gay men with HIV is nevertheless discernible and is articulated as a matter of self-blaming. The idea of blame emerged in accounts of other experiences with the management of risk:

I mean that really was the last time I'd had unprotected sex until my diagnosis and then I carried on with my ex-partner. I spoke to the doctor and he said: 'Well I wouldn't blame you if you had unprotected sex' (Robert: 1).

In the context of the present discussion, the link between the advice from the doctor and blame has the effect of a pun on the colloquial use of the phrase 'I wouldn't blame you' and the more severe implied judgement of behaviour that appears to be linked with the HIV prevention imperative. The example also constructs an exterior "... judging

authority” in the governance of HIV prevention (Foucault, 1990: 61). Robert uses the device of the reported speech of a medical expert to adjudicate on an aspect of HIV risk. The expertise of medicine is therefore used to temper blame. These different forms of internalisation of blame appeared to be what others have called ‘symbolic violence’ where public health messages lead people to blame themselves for poor health and adverse events (Bourgois, 1998). Galvin has also suggested how health governance implies that poor health is a kind of failure of moral duty (Galvin, 2002). It seems that gay men with HIV have a duty to act in a certain way in sexual situations. But it may also be the case that they are pre-judged as somehow to blame because of HIV positive serostatus.

The ethics of risk management in the post-crisis situation

The previous sections have explored the differing self-surveillance emphases of both treatment and prevention. I have argued that the idea of post-crisis brings these two disciplines close together. In particular, they are both implied in the formation of post-crisis identity for the gay man with HIV to do with responsibility and blame. A key distinction is that reflexive treatment is open to mutable HIV and therefore permits forms of self-care and risk management suited to post-crisis innovations, while HIV prevention is imperative, universal and confers blame. In this regard, the interviewees identified various ways that the disciplines of treatment and prevention overlapped in sexual practice. Unlike policy accounts of the prevention imperative that require altruism on the part of gay men with HIV, the interview accounts implied some of the other ethical aspects of risk management in lived experience. In the following discussion, I explore three aspects of these intersections of innovation and imperative. First, I consider a kind of negation of self in matters of risk management expertise. In the next part of the discussion, I explore accounts of methods for resisting blame for

HIV transmission in sexual practice. In the last part of this section, I suggest how risk management in the post-crisis situation involves a mixing of an adapted altruism and free agency, both of which rely on cooperation in sexual relations.

Self-negation

The previous section mapped out the blaming qualities of the HIV prevention imperative for gay men with HIV. However, in some situations, the imperative of preventing HIV turned into self-negation. Specifically, in connection with questions of HIV risk of the contestable kinds, the person with HIV could disqualify themselves in matters of risk management. Stephen provided an account of how he used a counsellor to help his HIV negative partner consider HIV risk in their sexual practice:

Stephen: ... one of the purposes of taking the counselling was for me to sit there while somebody else told him [HIV negative boyfriend] what you can and can't do. Because if I tell him, no matter how well, or I suppose badly, I couch it, it could always have a pejorative influence, and clearly that's something that one would seek to avoid.

MD: And how come you went for that option?

Stephen: Well, there were various options. I mean I wanted somebody who was a professional, who knew what they were talking about to tell him or give him literature and reassure him about what is and isn't possible. You know, obviously it's to preserve his state of health. He's never been tested but, you know, he just never, I'm pretty sure that he knows what he's doing.

MD: Why didn't you think you could do that?

Stephen: Well because no matter how I couch it there's always the possibility that I'm just saying what suits me. And I don't want him to think that. And also, I mean it was quite a good, you know, what better way to demonstrate that what

I'm telling is the truth than taking him to someone who ain't gonna tell him a lie
(2).

This account was figured to reveal a subject who could not be implicated in the provision of misleading information regarding HIV prevention. The account mobilised altruism in terms of the prevention of HIV infection of the other. However, the notion of altruism was taken further in this account. For example, "... there's always the possibility that I'm just saying what suits me" revealed a distrust of self. It seems that the prevention imperative combined with some risk considerations, specifically of the contested kinds, creates problems for the risk management legitimacy of the self. If HIV transmission considerations were absolute there would be no contest about risk assessment and therefore of the conduct of the person with HIV. But in a contested field, the altruistic person with HIV is required to step aside in matters of risk administration. Phrases and words such as "... ain't gonna tell him a lie" and "dispassionate" revealed a self with HIV compromised through self-interest. This self-negation resembles the self-satellisation of reflexive treatment discussed in the first parts of this chapter. But in this situation, the HIV imperative 'borrows' the method of self-satellisation. This is a kind of mingling of treatment and prevention disciplines that gives rise to the reflexive operation of bracketing out of the self. It is also noteworthy how this self-negation is achieved with the collaboration of the clinic. In this sense, the involvement of the clinic underlines the origins of self-satellisation in systems of self-objectification derived from medicine and psychology. Such self-negation is also suggestive of the perspective that uncertainty has regulatory purposes (Adkins, 2002; Burchell, 1993). Uncertainty connected with treatment effects does not imply equivalent social actors. Conversely, such uncertainty intersects with HIV serostatus to create

different risk management positions for the person with HIV, the uninfected and experts.

This sense of a limitation on the risk management capacities of the person with HIV is also traceable into a specific distribution of expertise in risk management. Continuing his account of risk management with his negative partner, the interviewee reflects on the benefits of drawing on the expertise of a counsellor:

MD: But why would a professional not lie? Why would they be in a better position than you?

Stephen: Well because they're completely removed from it, they're dispassionate about the whole thing they're removed from our relationship. If I say it's safe to do X and Y and it turns out that it's only partially, and it's partially unsafe to do X and Y, that can be interpreted as something I've kind of manufactured because it's something that I wanted to do. If someone who isn't involved in the relationship says here's a piece of paper and it tells you what you should and shouldn't do.

MD: But a lot of the kind of information is fairly uncertain, so why would a professional be in a better position?

Stephen: Well, because what is printed and what is being touted by the professionals, I mean it's rather like a stockbroker's stock recommendation list, there's no guarantee they're all going to make money but they are removed, you know, they assess these things and they produce what they believe to be the answer (2).

This account reveals much about risk management expertise. Professional advice was not seen as perfect. But it seemed to be preferred over the narrator's own knowledge

and action. Such expert knowledge was not necessarily better, but it had value because it was derived from a source that had legitimacy in HIV risk administration and outside the blaming that is conferred on people with HIV. This legitimacy arises because professional advice was derived outside the sexual relationship and is free of the imperative attached to HIV positive serostatus. This use of professional advice positions the self as less capable, but it also positions the expert other. Importantly this is not a hierarchy of knowledge in an absolute sense. It is a hierarchy of self-interest for an uncertain domain of risk management. This arrangement reveals a dis-trust of self and a reliance on relations with the 'objective' and uncompromised practitioners of risk knowledge located in the institutions of HIV medicine. The prevention imperative combined with the contestable aspects of HIV risk management helps install a sense of lack, a hollowing out of the self-sufficiency of the individual. This hollowing out suggests that the mingling of treatment and prevention in post-crisis can lead to a contradictory mixture of required responsible action and compromised expertise on the part of gay men with HIV.

Resisting blame

As I discussed in chapter three and at various points in this chapter, prevention policy about people with HIV is pre-occupied with a question of installing and furthering responsible action (Kalichman et al., 1997; King-Spooner, 1999; Russell, 2000). And in connection with the contest over sexual conduct in post-crisis, gay men with HIV are sometimes depicted as 'resisting' HIV prevention advice (Crossley, 2002; Goodroad et al., 2000). These two post-crisis themes are aspects of the contest about the responsible behaviour of gay men with HIV in the management of the epidemic. In contrast however, the interviewees appeared to be concerned with the articulation of responsible action in their sexual practice more in keeping with the idea of self in sexual community and the

ethical considerations of risk management practice (Crimp, 2002; Weeks, 1998). And in addition, rather than rejecting HIV prevention per se, the accounts provide reason to argue that gay men with HIV are concerned with avoiding and resisting the blame that comes with the HIV prevention imperative. And blame is resisted, partly through the idea of free agency of the self and the sexual partner. Freedom is therefore not articulated with the prevention imperative as such, but with its associated connotations of blame and moral judgement.

Because of the blaming that comes with the prevention imperative the interviewees focused on strategies for mitigating blame for HIV transmission in sexual relations. In the next example, the interviewee expresses his concerns with HIV risk, responsibility and emotional well-being:

I don't want to have it on my conscience that I infected somebody. Because, I wouldn't be able to deal with that very well. That would fuck up there. That would fuck up more so than any other thing, knowing that I had actually infected someone, knowing what I do. Now if I did it unintentionally, if the condom broke or something, and it was their choice, they knew I was positive, then there's nothing I can do about that. But if I fucked somebody and knew that I should have used a condom, and they were negative and found out six months down the line that they were positive, I wouldn't be able to deal with that very well (George: 2).

In this account, the idea of infecting another person appears to have deep significance for the narrator. But there is also a distinction made between knowingly infecting someone and not knowing. The ethical responsibilities of the gay man with HIV are therefore connected with knowledge of serostatus. Lack of knowledge and happenstance were kinds of mitigation of blame.

HIV infection was not the only risk however. Rejection because of HIV status was also an aspect of sexual relations for the interviewees:

And the thought of being with somebody and then after having had sex or after having seen them for a while then telling them or them finding out and then rejecting me seemed so horrendous that I couldn't bear the thought of that. So the sensible thing to me seemed would be to tell somebody first and if they were narrow minded or insensitive or scared enough to feel that they couldn't deal with that then that would be their choice, and that it was, you know, that it was just fair somehow (Michael: 1).

Apart from considerations of blame, there was also a desire to avoid and minimise social rejection. In this account therefore, the narrator mapped out a way of managing rejection that centred on sharing knowledge about his HIV serostatus allowing the sexual partner to make a choice about whether or not to have sex. In chapter five, I identified that one of the aspects of the post-crisis experience was a requirement to make HIV and forms of ailment invisible, in social intercourse or in the clinic. Conversely, to minimise their own negative experience in sexual relations, gay men with HIV are required to make HIV identity visible to enable the other to act. The combination of these two requirements in lived experience is perhaps a source of contradiction for gay men with HIV, or at least suggests the differing and situated visibilities of self with HIV for the post-crisis situation.

Because of the prevention imperative, the possibility of blame and social rejection, sharing knowledge about one's own HIV serostatus was an important strategy for the interviewees. In this example, the interview suggests the importance of emotional well-

being in sexual relations and therefore the value of disclosing HIV serostatus:

I said: ‘I don’t know if you know but I’m HIV positive’. I said: ‘And I need to tell you this, because I don’t think I cannot tell you. It doesn’t feel responsible to me’ (Michael: 1).

In this example, the imperative turned into a self-imposed disclosure that promotes a sense of personal comfort. This is a different meaning of sero-status disclosure than that suggested in interventions for gay men with HIV (Imrie et al., 2002; Petrak et al., 2001; Vazquez-Pacheco, 2000). In this example, disclosure is about caring for one’s own emotional well-being and helps to guard against blame. However, as I discussed in chapter three, previous research has suggested that either with-holding or disclosing about HIV serostatus leads to difficulties for people with HIV (Cusick & Rhodes, 1999; Rhodes & Cusick, 2000). In particular, people with HIV were held responsible for HIV risk whether or not they had disclosed. As noted by other researchers, in some situations, through a “... cruel twisting of logic” people with HIV were blamed even when the other partner had decided to have sex without condoms with knowledge about the HIV positive serostatus of their sexual partners (Cusick & Rhodes, 2000: 481). It seems that the person with HIV faces a risk of being blamed for HIV risk in the sexual encounter, whatever they do. However, the accounts suggest that, on balance, there is wisdom in judicious disclosure for one’s own sake.

Another formulation for mitigating the negative aspects of sexual relations was to specify one’s own responsibilities in relation to those of the sexual partner. In the next example, the interviewee articulates a philosophy for responsible action that refers to free agency:

I don’t feel I am responsible for other people’s sexual health, in any absolute

sense but I think being HIV positive makes it incumbent on me to ensure that we do, that when I have sex, that the sex is safe for both of us to the extent that we both want it to be ... (Kevin: 2).

In this example, the ability to make informed choices emerges as a way of managing the social expectations of the HIV prevention imperative. In this situation, the interviewee constructs a role for themselves as a kind of facilitator of choice-making. This notion of the HIV positive person facilitating informed choices is an adaptation of the idea of altruistic conduct. In this method of risk management, the person is not responsible for HIV transmission in the larger moral sense. But they do have a role in helping to construct a social setting that supports risk management practice. Taken together, these accounts form a point of continuity in an acceptance that the person with HIV had certain responsibilities to themselves and their sexual partner in connection with the risk of HIV transmission. Moreover, acting in an adapted altruistic way enabled engagement with post-crisis prevention imperatives. Adapted altruism allowed the management of blame and therefore promoted well-being. And perhaps it also allowed the gay man with HIV to manage rejection.

The sero-identity of the sexual partner also emerged as an important feature of accounts about sexual relations and risk. In this example, the interviewee traces connections between the need to avoid HIV transmission risk, blame, rejection and a focus on the HIV serostatus of potential sexual partners:

... the only thing that's changed is the way I look at most partners. I'm more inquisitive into their status. I have to know. If they don't want to tell me it's fine, I just use a condom, that way there's no guilt coming back onto me (George: 2).

For gay men with HIV, the serostatus of the other takes on importance as a way of helping to construct the sexual setting and therefore informs action in connection with HIV risk. The question of serostatus of the sexual partner reveals an interest in the logics of the combination of same and different sero-identity. For this reason, risk management takes on a contingent quality informed by a kind of serologics of the combination of identities in sexual relations. The account also reveals the shades of meaning of the condom for the gay man with HIV. In this example, the condom has value because it can guilt-proof sex. Condoms are typically represented as a neutral technology of ‘protection’. It seems that for gay men with HIV, the condom has some specific social value and uses in risk management to do with avoiding blame for HIV transmission, along with reducing the risk of HIV transmission.

Another aspect of the accounts was the resistance of blame itself. Such resistance was achieved through the idea of free agency:

You see I think at the end of the day if two guys want to have unprotected sex I think it's a matter for them, actually. I'm not too sure that it's something I would ever consciously take a decision to do, but I really do think that it's not up to me to wag a finger at them if they choose to do it. And this [the advertisement] has a kind of finger-wagging quality of it. Which is made all acceptable because they're cute boys, and one cute boy wouldn't want to infect another cute boy (Kevin: 2).

This example foregrounds the “finger-wagging” quality of the prevention imperative. Post-crisis seems to sponsor a competition between conformity and resistance articulated around the blaming that comes with the requisite action of imperative. In this competition the idea of free agency takes on value as an ethical basis for resistance. It is also important to recognise that it is not HIV prevention as such that is resisted, but the

moral judgement that comes with it.

Combining altruism and choice in sexual practice

Sexual relations for gay men with HIV imply the ethical challenges of imperative and the desire to avoid and resist blame and social rejection. Accounts of risk management in sexual practice revealed that gay men with HIV appear to rely on an adapted altruism. Also, different sexual settings implied different dilemmas and contradictions. Therefore the choice or combination of ethical strategies was also situated in the circumstances of the sexual partnership. Risk management was not just a matter of altruism, but neither was it absent or in need of active cultivation, as suggested by some (Marks et al., 1999). Similarly, risk was not managed on the basis of an unfettered individualisation of self in sexual relations. Both these kinds of ethics of risk seem too atomised to provide a way of fully understanding how the interviewees depicted risk management. Instead, risk management in sex seemed to be informed by cooperation, which makes sense given the relational aspects of sexual interaction. This vision of cooperative ethics is close to the idea of reflexive 'we' or reflexive community suggested by Lash and Adkins (Adkins, 2002; Lash, 1994). In this regard, problems for gay men with HIV in the post-crisis situation are traced into the insufficiencies of individualised action informed by limited constructions of either altruism or self-interest. The accounts therefore suggest the need for legitimising and expanding the value of cooperative action in sexual relations.

The notion of altruism on the part of gay men with HIV was a recurrent theme of accounts of the management of HIV transmission in sex. Thomas provided an exemplary depiction of a 'pure' altruism:

Thomas: ... I think that stopping other people getting it is more important than boosting the morale of people who have it.

MD: What do you mean?

Thomas: Well I don't think anything is more important than cutting the rate of communication of the disease and I don't think you should start playing down the illness and using more soothing words about it just to help the morale of people who have got the disease if a by-product of that is lessening the safe sex message (2).

This prevention altruism is unilateral and figured around an ideal of an infallible person with HIV. It also summarises how post-crisis risk governance can become a contest between containing HIV infection and furthering the health and well-being of people with HIV. In contrast, in the situation of sexual interaction, the sharing of responsibilities appeared to be relevant. In this example, the interviewee discusses risky sexual practice:

I 'spose that part is pretty scary for me. If he [HIV negative boyfriend] did go and get tested and he did come back HIV positive, I wouldn't be blaming that on myself, because we're both in it together. But I would hope that he would cope with it in the same way that I had, 'coz I wouldn't want all that stress and that responsibility of looking after another person if they were unable to deal with that situation, 'coz I think that would make things very messy. I mean we have fucked without condoms and that's been a decision of his and of mine (Edgar: 2).

In the situation of a regular partnership, risky practice is constructed as a joint decision. In particular, blame is deflected because the decision to have risky sex is seen as a shared one. Accounts such as these reveal a challenge for the HIV prevention imperative in relation to its reliance on individualised social action. The imperative has

not found a way of addressing the ‘we’ of risk and the joint action it implies. In the next example, with reference to the risk of reinfection, the interviewee also relies on the notion of shared responsibility:

MD: I mean who’s responsible for what type of thing is the kind of question in there.

Robert: Yeah, I mean ultimately you both are if you’re in a relationship and you make the decision to have unprotected sex, and it’s a joint thing really isn’t it.

MD: Some people say positive people need to take more responsibility because they are infected.

Robert: Oh yeah, yeah.

MD: Do you think that’s right?

Robert: I think it’s certainly a point really isn’t it. Because I suppose selfishly for yourself you could be reinfected with a sort of more virulent strain of the virus, or a drug-resistant strain. And yeah, it is a point I suppose. But then the other argument is that, being HIV positive you’ve got enough problems without having to wrap yourself in rubber when you have sex I think you’ll find that a lot of positive people would have unprotected sex with others of the same status (Robert: 2).

“We’re both in it together” and “... it’s a joint decision” both underline the relational dimension of the articulation of the ethics of risk management. Sharing also seems to pertain to the situation of the regular partnership. In other relational settings however, responsibility shifted. In this extract, the interviewee refers to sex with a casual partner:

I think that's primarily his responsibility. I won't engage in behaviour which kind of wilfully puts him at risk if you see what I mean. I wouldn't try and persuade him for example to do something risky with me. But there's a sense in which he

was indicating what he wanted. I mean he wanted a bareback fuck and really if he decides on that course then the risk is his (Kevin: 1).

In this situation, the gay man with HIV is not responsible for the risky actions of the other person. These forms of risk management differ from the more unilateral risk altruism: “I think that stopping other people getting it is more important than boosting the morale of people who have it ...” (Thomas: 2). Risk management in casual sexual settings seemed to rely on a discourse about situated dispersal of responsibilities. But even when it was accepted that the gay man with HIV was not singularly responsible, the HIV prevention imperative lingered to provide a source of doubt. In this example, the interviewee reflects on risky sex with a casual partner:

I didn't take a conscious decision to have bareback sex with him. I mean, you know, we were in the cubicle and it became very plain he wanted to fuck me and I was off my face and so was he. And so he did. As he entered me I thought he hasn't got a condom on. But at that point you think: ‘Well I'm not going to stop now because it's leaving it too late’. We hadn't negotiated anything and if you stop it after that point you can ruin the act in a sense. So we didn't stop it. I didn't stop it. He didn't stop it. And, I suppose since then it's been at the back of my mind. I feel I shouldn't have done that. I feel I shouldn't have got myself into that situation, and so I haven't got myself into that situation since it may well have been that if I'd told him beforehand I was HIV positive he would have put a condom on. I think he was ignoring the risks he was taking. And I think given that I knew that he was taking a risk in screwing me without a condom, I think the sensible thing and the fair thing to do would have been to have told him put a condom on (Kevin: 2).

The interviewee rather bravely identifies the precarious qualities of sex in post-crisis. The reflection on the event also realises a kind of flux in the self-subjection of 'we', 'I' and 'he' in the prevention imperative. There is an underlying question of a failure to act in the right way, either on the part of the self or the sexual partner. It seems that there is something missing in HIV prevention rationality to do with its engagement with the situatedness of joint sexual action. There is also a subtle distinction that is not always aired in HIV prevention discourse with reference to gay men with HIV. Risky sex appears to have negative consequences for the ethical carriage of self and emotional well-being. The account also reveals a kind of self-education where the narrator reflects on the experience and determines that making the other person aware of one's own HIV serostatus may, in the end, comprise an act of self-protection. But this strategy is not complete. As I have mentioned, people with HIV can be held responsible for HIV risk in risky sex, even when they share knowledge about HIV status with prospective partners (Cusick & Rhodes, 2000).

These accounts suggest a role for a kind of cooperative ethics for joint action in the post-crisis situation. Risk management in sexual relating was a mixture of self-serving and altruistic social action, which exceeded questions of viral transmission to encompass questions of the resistance of blame and the promotion of emotional well-being. Disclosing about HIV status was seen as "sensible" as it allowed the sexual partner to make a choice about whether to continue with the sexual encounter. In the same way, encouraging the use of condoms was also "sensible" and "fair". However, the other person was free to choose unsafe sex, for example: "... I mean he wanted a bareback fuck and really, if he decides on that of course then the risk is his" (Kevin: 1). These quotations suggested that the sharing of responsibilities was shaped around an ideal of free agency, perhaps an application of a neo-liberal rationality to HIV risk

management (Adkins, 2002). The interviewees did not see that they were responsible for the risky choices of the other person. Moreover, returning to the quotation used at the beginning of the chapter, it seemed that the interviewees were at pains to distance themselves from risky sexual behaviour on the part of other people:

“... it has nothing to do with me it’s your life, you do as you please with it, you know, if you want to kill yourself, fine ‘coz we all have choices in life it’s their choice, not mine (George: 1).

“It’s your life” made it seem as if life was an individual possession, an idea that seems consonant with reflexive biography and neo-liberal constructions of self. Behaviours that were likely to transmit HIV to a negative man were depicted as abhorrent. But in the context of neo-liberal social action, these were also seen as possible, if repugnant individual choices. Another way of expressing this social judgement was plurality:

I feel such a hypocrite when I’ve had unsafe sex with my boyfriend sort of passing judgement on people going to clubs and doing it that way, because it’s really not that different. But I don’t know, we all have our levels of where we think, you know, is right and wrong (William: 1).

“Right and wrong” signified a moral order. The idea of responsibility is worked out in sexual practice so that it is shared in ways that do not compromise the idea of individual choice. The personal experience accounts suggest that ethical conduct appears to be a situated articulation of altruism, free choice and cooperative action. However, the universalising quality of the HIV prevention imperative, focusing as it does on altruistic but individual action of gay men with HIV, appears to underplay the importance of relationality, cooperation, concerns of ethical carriage of self and blame.

Summary

This chapter has focused on extending an account of the post-crisis situation for gay men with HIV in connection with innovative and imperative. I have argued that innovation and imperative are implicated in the construction of the identities of gay men with HIV. I have explored how the language of medicine and psychology is used to ‘satellise’ and objectify the self, for example, in metaphorical language and wordplay such as “... shagged by another virus” (Edgar: 2). But these self-objectifying operations were not necessarily negative or unhelpful. For instance, they enabled innovation, a changeable self with HIV, self-care, and new kinds of risk relations. But I also attended to how the imperative of HIV prevention was brought into self-understanding and through it, blame for HIV transmission. Accordingly, blame was resisted, creating an important focus for the sexual action of gay men with HIV. The importance of HIV identity in the post-crisis experience is ironic when compared to the accounts of living with HIV treatment discussed in chapter five. In particular, I noted how gay men are required to make AIDS invisible and the treatment of HIV and its ramifications a personal matter. Conversely, a visible, public HIV identity seems critical to sexual relations in the post-crisis situation, particularly as a focus for achieving HIV prevention. In the next chapter, I build on these perspectives of innovation and imperative in connection with the uncertain and contestable treatment-related knowledge about viral variation and implications for HIV transmission risk.

CHAPTER SEVEN: UNCERTAINTY, CONTEST AND TREATMENT-RELATED KNOWLEDGE

I just believe HIV is HIV [laughing] There's not much more that can go wrong once you've already got it ... (George: 1)

I mean there's no kind of, you know, you're either infected or you're not, there is a huge degree of, you know, you can be very badly infected, you can be a bit infected, and, you know, if you alter that ratio, I mean the drugs alter it so that you're only a bit infected ... (Stephen: 2)

Introduction

Chapter five used interview accounts to discuss the meanings of living after the advent of treatable HIV and applied them to a critique of the orthodox construction of treatment optimism. Chapter six considered identity in connection with treating and preventing HIV and some of the challenges that arise in sexual practice to do with the mingling of innovation and imperative in the post-crisis situation. This chapter draws on these previous analyses to address risk knowledge associated with HIV treatment, in particular, reinfection and viral load. As such, it addresses one of the key themes in post-crisis discourse to do with the possible effects of treatment-related risk knowledge in sexual practice. In chapter two, I outlined how the advent of treatable HIV is associated with a sense of HIV varying in amount and type: reinfection and the related notion of drug-resistant virus; and viral load blood test results and implications for risk of HIV transmission. These two aspects of HIV treatment are important for risk management in respect of clinical care and sexual practice. In particular, drug-resistant

virus and viral load suggest multiple and variable risks for HIV transmission in sexual relations. As I established in chapter two, the risk implications of these aspects of treatment have contestable technical bases and have contentious implications for risk management. It remains uncertain whether reinfection is a risk to health and there is debate about whether knowledge about low viral load might lead to risky sex. The interviews suggest further complexity. There was no universal effect of knowledge about reinfection or viral load on perceptions of risk in sexual practice. Moreover, interviewees had diametrically opposed views about both reinfection and infectiousness, opting for absolute or relative interpretations of risk. I will consider these preferences in terms of several theoretical perspectives: risk management choices as a reflection of cultural practice (Douglas, 1992; Douglas & Calvez, 1990); the idea of 'precarious freedom' connected with the risk society idea of manufactured uncertainty (Beck & Beck-Gernsheim, 2002); and the proposition of the break-up of meta-narrative concerning HIV risk knowledge and sexual practice based on post-paradigmatic perspectives on sex and sexualities in late modernity (Plummer, 1995; Simon, 1996). I want to argue that the division in risk management preference means that, unlike orthodox accounts of the impact of treatment in sexual practice, post-crisis is more properly conceptualised as open to the circulation of both 'paradigmatic' and 'post-paradigmatic' constructions of risk. I will make this argument in two parts. The first part of the chapter concerns interpretations of reinfection risk and implications for sex with other men with HIV. The second part of the chapter considers viral load and infectiousness and how this knowledge was considered in connection with sex with HIV negative partners, or partners who did not know their HIV status. Parts of this discussion are an extension of a previous analysis of these data (Davis et al., 2002).

Reinfection and drug-resistant HIV

In this section, I will address how the interviewees interpreted the risk implications of the ideas of reinfection and drug-resistant HIV in relation to their sexual practice. Reinfection brings about a dual sense of risk (Boden et al., 1999). It is a risk to the self in terms of reinfection with drug-resistant HIV and therefore reduced treatment options. But reinfection also implies the spread of drug-resistant HIV through the population, thereby reducing the overall effectiveness of treatment. The idea of reinfection is therefore one that embraces individual and public risks. “Shagged by another virus” (Edgar: 2) was introduced in chapter six as an objectification of the person with HIV infection in the situation of mutable virus connected with the advent of treatable HIV. I will use accounts of reinfection risk to continue the argument against the idea that the post-crisis situation is simply a totalised subsiding of danger leading to changes in risk practice. Instead, I will suggest that gay men with HIV are aware that risk knowledge is provisional and contestable. In this situation, social actors have to choose a position about how to approach the uncertainties of reinfection risk with reference to achieving the HIV prevention imperative. Preference for one method or the other is therefore not just informed by technical knowledge. It also concerns engaging with the ethical considerations connected with preventing HIV in conditions of uncertainty. However, the articulation of preference also contributes to the breaking up of a universal way of thinking and acting about treatment and sexual practice. In particular, the interviewees made interpretations of the riskiness of reinfection for sexual practice through the notions of absolute and relative risk. The absolute position connotes categorical HIV serostatus identities and universal risk management, both of which can be traced into a period of the epidemic prior to the advent of treatable HIV. The relative position is one of varying, multiple risks and questionable identities. This position is derived from the technical innovations that have helped constitute the advent of treatable HIV. I want to

suggest that instead of the watershed idea of replacement of one way of thinking about risk for another, a mode of analysis that permeates HIV research and policy about post-crisis, there is the ‘recycling’ of the absolute position to resolve new concerns linked with the advent of treatable HIV, along with the emergence and differentiation of relative constructions of risk. In the following discussion, I address three aspects of this argument. First I will establish the absolute and relative perspectives on the idea of reinfection. Then I explore how the idea of viral sameness is taken into sexual relationships as a way of managing reinfection risk. In the last part of this discussion I will make note of how enduring doubt about whether or not reinfection may jeopardise health seems to contribute to insecurity in sexual partnerships and underlines the importance of cooperative action in the ongoing management of HIV risk.

Multiple HIV or “... HIV is HIV”

The interviewees had differing interpretations of the idea of reinfection. In this regard, some interviewees relied on a sense of relative risk and therefore engaged with the idea of multiple and therefore possibly, drug-resistant forms of HIV produced by treatment. Alternatively, in other accounts such a notion of HIV was set aside in preference for a more absolute construction of risk, and therefore in terms of reinfection, the idea of a single form of HIV. In the following examples, the interviewees appear to accept the idea of more than one virus, that reinfection was possible and that it could have negative health effects:

... I think it’s a sensible thing, even if both of us were HIV positive, I believe that there’s probably more than one strain of HIV (Peter: 1),

... about a year ago I would have said: ‘Oh, okay, fine.’ But since I have realised and learned that it really doesn’t matter because you can actually re-infect

yourself or you can re-infect someone else (Bruce: 1).

These interviewees positioned themselves as cautious about risk knowledge and particularly acknowledged the idea of variable and drug-resistant virus. These examples also reflect engagements with the implications of the idea of multiple virus for sexual practice.

In contrast, interviewees also relied on the idea of one HIV. In the next quotation introduced at the beginning of the chapter, the interviewee uses the idea of a singular HIV to make an assessment of the health risks of reinfection:

I just believe HIV is HIV There's not much more that can go wrong once you've already got it ... (George: 1)

In this construction the idea of reinfection or viral variation is deflected for a singular form of HIV infection. Based on this assumption, sex with another HIV positive man was preferable to sex with HIV negative men:

George: And see I won't go home with anyone who's negative now, at all.

MD: Really?

George: No. I might toss them off, but I won't go home and have sex with them.

MD: Because?

George: It's too much of a hassle. And I worry about infecting them (2).

George's account revealed a sense in which the health impact of reinfection was secondary to the problems of HIV infection per se. His account also connected with those of the previous chapter where men were concerned to reduce the risk of blame in the sexual encounter. Roger used the same language as George:

I am still a bit confused about all of that. HIV is HIV to me. Either you're HIV positive, or you're HIV negative. It's as simple as that, you know. All these different strains, drug resistance ... [later] ... you're already infected by the virus. Yes you can stand to be infected by other diseases, but you've already got the main one ... (Roger: 1).

In the face of the propositional character of the idea of reinfection, Roger also deployed an absolute meaning of HIV risk. The central idea of these constructions was that HIV infection was superordinate to any further infection, a situation that simplified risk decisions under conditions of uncertainty.

The contrast between the acceptance and rejection of the risk implications of reinfection implied the circulation of relative and absolute constructions of risk. Absolute constructs like "... HIV is HIV" mirror the risk relationship produced by the HIV antibody blood test because the identities of sero-positive and sero-negative seem categorical and definite. Absolutism is therefore also a 'pre-treatment' form of risk discourse because it reflects the form of risk management associated with the HIV antibody blood test that developed prior to the advent of effective treatment (Flowers, 2001). In a sense, "... HIV is HIV" refers to the 'crisis' epoch. Conversely, risk relativism is consonant with the supposed fragmentation effects of HIV medical technologies (Flowers, 2001). The notion of virus varying by type and amount flows out of changes in the treatment of HIV and the use of medical technologies to monitor the proliferation of drug-resistant forms of HIV. Relativism therefore engages with risk as a scientific enterprise of measurement and variation. The notion that "... there's probably more than one strain of HIV" is an example of how risk is reconfigured via HIV treatment (Peter: 1). In this respect, we can see that the absolute and relative risk

interpretations can be traced into the confluence of changes in medical knowledge about risk and gay community practices of safer sex.

Strikingly however, the interviewees provided accounts that seemed divided into either absolute or relative interpretations of reinfection risk. The interviewees seemed concerned to take up either absolute or relative positions. This division was not a technical one. Instead, interpretations of reinfection seemed to reveal different engagements with the provisional and contested knowledge about reinfection. As suggested by Douglas with reference to risk in general, such preferences can be viewed as aspects of a cultural engagement with the uncertainties and knowledge contests of post-crisis (Douglas, 1992). Giddens has noted that the subject of late modernity is required to: "... ride the juggernaut in hopeful anticipation, [and] never feel entirely secure" (Giddens, 1990: 139). Engaging with the risky qualities of HIV treatment (such as reinfection) is somewhat like riding a juggernaut, particularly in respect of aiming to reduce risk. Giddens has also proposed that the individual in risk society is faced, not with simply technical problems, but with decisions about values:

... one of the most characteristic features of modernity is the discovery that the development of empirical knowledge does not in and of itself allow us to decide between different value positions (Giddens, 1990: 154).

In the case of post-crisis, changing and uncertain technical knowledge has opened up dilemmas for gay men with HIV. In this light, absolute and relative constructions of risk are different methods for engaging with the dilemma of uncertainty. Following Beck, Lash has used the idea of "... precarious freedom" to characterise risk reflexivity in connection with technology:

... it is at the interface of the social and the technical that we find the second-

modernity's individual. It is at this interface that we take on the precarious freedom of a 'life of our own' (Lash, 2002: xiii).

I want to suggest that via knowledge contest and the valorisation of the reflexive self, preference has become the principal method for engaging with post-crisis forms of risk. This notion of preference in the situation of precarious freedom also permits a connection with the expressive/aesthetic qualities of care of the self explored in chapter five. That analysis suggested a hermeneutics of self-care in respect of the sometimes paradoxical aspects of hope and uncertainty and the various responsibilities and requirements of self-care. For reinfection, absolute or relative approaches are both legitimate forms of risk management. The rejection of the prospect of viral variation and its risk implications or alternatively a 'letting in' of treatment-related variable HIV and variable risk are both justifiable in the circumstances of provisional, contestable and expanding knowledge about HIV treatment. Preference therefore represents one's stance in the situation of the ethical challenge of uncertainty and contested knowledge connected with reinfection.

I also want to argue that this situation of different methods for addressing HIV risk resonates with post-structural ideas about sex and sexuality. As I noted in chapter two, analysts in the area of sexualities have discussed how the late modern era is open to multiple speaking positions (Plummer, 1995: 142). Dominant ways of thinking and acting are open to contest: "... post-paradigmatic contexts are those where seamless integration of consensual meanings begins to dissolve" (Simon, 1996: 9). Given that an absolute construction of risk has origins in a period of the HIV epidemic prior to the advent of treatable HIV, I want to suggest that it is 'paradigmatic'. It is a risk position of categorical and universal implications for sexual practice, signified by constructions like

“... HIV is HIV”. It is a risk approach that also supports the HIV imperative of identity-related responsible action. Relativism can be taken to be post-paradigmatic in the sense that it questions a paradigmatic ordering of risk. Relativism is a challenge to paradigmatic constructions of risk, but it does not overwhelm. Post-crisis risk governance is therefore experienced as the co-existence of the paradigmatic and the post-paradigmatic articulating with preference. There is no watershed, or overturning of the ordering of risk. Post-crisis is a time of uncertainty and contested risk knowledge where the principal challenge for the self is ethical rather than technical. Therefore preference becomes the principal method of resolving ethical considerations. This perspective sits in opposition with the orthodox treatment optimism literature, which is figured around watersheds, totalities and linear determinations of knowledge and behaviour. In addition to the previous argument about post-crisis meanings, I want to suggest that in the post-crisis situation, the practical achievement of the HIV prevention imperative is mediated by the preferences of reflexive actors engaged with the ethical implications of knowledge contest. Moreover, the ambivalent empirical findings of the treatment optimism literature noted in chapter two, may in part be explained by the circulation of different risk management preferences in a situation of contested knowledge about risk.

The value of sameness in sex with men with HIV

Viral sameness was also an important theme of accounts about reinfection. The prospect of different genotypes of HIV leading to drug-resistant forms and therefore to the putative risks of reinfection, had the effect of drawing attention to whether one's sexual partner had the same form of HIV or not. Viral sameness therefore had resonance with both paradigmatic and post-paradigmatic thinking about HIV risk. In the following extract, the interviewee makes reference to a decision about whether to use condoms

with another man with HIV:

Robert: As regards the HIV, I suppose really we should have got our doctors to put their heads together and find out if we had the same strain of the virus, but I was strongly inclined to feel that we did have.

MD: How come?

Robert: I think we were sort of infected at about the same time. I don't know, it's a silly assumption really isn't it? You know, it wasn't sort of based on anything. sort of scientific fact. But you know I spoke to my doctor here about it: 'What do you think about us having unprotected sex?' And he said: 'Well I would go ahead. I really wouldn't worry about it' (1).

This account combines advice from a physician with a notion that the interviewee's virus and that of his partner were "... the same" in terms of both genotype ("strain") and a temporal ordering of the epidemic ("time"). Reported speech has the effect of positioning the narrator as unsure and questioning, perhaps a replaying of self-satellisation in matters of risk governance noted in chapter six. We can also see, as with other forms of the more contentious aspects of risk, how technical knowledge of the contested kinds is brought into interviews through the voice of a medical expert. Robert's construction of reinfection risk also mobilises a viro-social ordering of risk meanings. According to Douglas: "... the symbolism of the body's boundaries is used ... to express danger to community boundaries" (Douglas, 1966: 124). It seems that the sexual partner thought to have similar virological characteristics becomes a copy of the self. In that regard, there is therefore no danger in reinfection. Therefore, one of the aspects of reinfection is to draw attention to the sexual relationship defined in virological terms. In the next example and like the previous one, the interviewee refers to viral sameness:

We both spoke to our doctorswe'd made a decision within the first couple of months that we're going to have a monogamous relationship, and there was a lot of talk then about what were the possibilities of cross-infection. And the issues of drug-resistant virus weren't applicable because neither of us had ever taken any of the drugs. And so we thought well, neither of our doctors, who are both very well versed and experienced in HIV medicine, neither of them could find any reason why we shouldn't, although they couldn't definitely say that it wouldn't be a problem. They said: 'There may be some risks but it seems unlikely because it's not like you have different strains' So their feeling was that as long as we were both absolutely sure that we were being faithful to each other then it really probably wasn't going to cause a problem. But that it shouldn't go just on the advice and because they didn't know still. So it was up to us. And so we chose that we wouldn't use condoms, and we didn't (Michael: 1).

As in the previous account, reported speech was used to depict contentious risk determinations. The depiction gives the impression that the interviewee, his partner and their physicians were at the frontier of knowledge about risk. But in this frontier, the interviewee and his partner were also made equivalent in virological terms, in a way that resembled the notion of simultaneity of infection articulated in the previous account. As with other aspects of treatment discussed in chapter five, uncertainty about risk appears to give rise to responsabilisation, but in this situation, the monogamous gay male couple become the 'unit' of responsabilisation. This situation led the couple into a kind of 'bricolage' of risk assessment, drawing together technical information, a stance about reinfection and 'negotiation' between the sexual partners.

These judgements of viral equivalence either in terms of simultaneous infection or

treatment naïveté reveal an assumption of an epidemic unfolding and changing over time. Simultaneous infection supports an idea of one epidemic affecting people over linear time. The notion of treatment naïve virus also places subjects in a time sequence, but in this respect figured around the intersection of personal biography and the advent of treatable HIV. These constructions resemble illness narratives used to explore living with HIV infection discussed in chapter two and considered again in chapter five. This resemblance arises in the importance of a temporal logic, of an ordering of selves in epidemic time, in particular, in terms of the advent of treatable HIV. In addition, these interpretations of sameness (and by implication, difference) in connection with the prospect of reinfection, resonate with paradigmatic and post-paradigmatic constructions of risk. Preventing HIV becomes a matter of determining sameness and difference when considering HIV prevention with someone else with HIV infection. Sameness, and therefore a paradigmatic sense of a shared, single virus, implies that there is no risk of reinfection. Difference, and therefore the post-paradigmatic sense of multiple viruses, implies the need for precautions against reinfection. The risk considerations of reinfection therefore appear to have a kind of ‘Russian Doll’ quality. If one subscribes to the paradigmatic perspective, ‘HIV is HIV’, reinfection is not a risk in sex with someone else with HIV. But one can also apply post-paradigmatic constructions of risk to knowledge about the viral type of a prospective partner with HIV.

Insecurity in sexual relations

Some interviewees appeared to find that reinfection was not a health concern in connection with a paradigmatic notion of HIV risk. However, the interviewees expressed enduring doubts about reinfection risk suggestive of manufactured uncertainty. In particular, doubts were expressed even when interviewees had decided to have unprotected sex with other HIV positive men. These doubts were traced into the

provisional quality of knowledge about reinfection and the related contest over conduct. This doubt seemed to resonate with the notion of precarious freedom or Giddens's idea of 'juggernaut'. In this example, the interviewee expresses some discomfort about the risk of reinfection after advice from a clinician:

Well with him he didn't see the need to have protected sex. I wasn't, you know. I could see his point but I was in two minds. So I consulted my doctor and he said: 'I really wouldn't worry about using condoms' but I must admit, I didn't sort of particularly feel comfortable with it (Robert: 2).

"I didn't sort of feel comfortable" suggested that the interviewee had a problem resolving medical advice, his own and his sexual partner's risk management preferences. "In two minds" signified awareness of several competing perspectives on reinfection risk and therefore a dilemma for action and security. This problem was also expressed as a "quandary":

I was in this quandary when I was in this semi-relationship with this positive person and just talking to other people about it, it was brought up that you can get reinfected or infected ... (Malcolm: 2).

These perspectives draw attention to the relational aspects of risk management, including both the sexual partnership and engagement with medical experts. They stress how managing the risk of reinfection implies social negotiation of expert knowledge, shaded personal preferences and the articulation of these with a desire to achieve a sense of security in sexual practice. In this situation of doubt, sex without condoms with another man with HIV was a source of concern:

Well, when we both found out we were positive, we used condoms at first and then he kept saying: 'You don't have to use condoms', and I said: 'I can reinfect

you and you can reinfect me', I said, 'I don't think it's a good idea'. But we did actually. We did about three or four times, we did have unprotected sex ... I thought: 'Well, no, I'm just not sure, I can't afford to catch really, anything, or make things, matters worse' (Philip: 1).

In this example, reported dialogue helped to depict a sexual other as if to underscore the negotiated and relational quality of risk management. These accounts suggest the discomfiting articulation of different preferences for managing the risk of reinfection. These risk concerns could also be differentiated by other considerations:

Philip: If you reinfect yourself, there might be drug-resistant strains of HIV and you're just asking for trouble, really, but then again, you've got to think about quality not quantity of life. Sometimes it's best to have a good time for one or two years than live miserably for ten.

MD: So what is your position then, what do you think about that?

Philip: I'm not really sure. Depends on the person, whether they want unsafe sex or not. If they're negative, then I won't sleep with them without a condom. I won't infect them, but if he's positive, it depends on the other person. I will sit there and talk to them about it. I say: 'Well look, what do you want to do? Do you want safe or unsafe? I would prefer safe still'.

MD: Even with a positive guy?

Philip: Even with a positive guy, but I'm open to negotiation. It depends on the circumstances. How ill he is. If he's ill, it's something I'd have to go and think about first (1).

In this account, the risk considerations of reinfection are extended in several ways. Overall quality of sexual life is brought into consideration. The notion of "... how ill he

is” suggests the introduction of risk relativism that resonates with the idea of mutable HIV. However, “... I would prefer safe still” suggests an ongoing insecurity about sex with other HIV positive men. It may be that one of the unwanted aspects of the advent of treatable HIV concerns insecurity in sexual partnerships between HIV positive gay men. This is not treatment optimism as such. In contrast, these accounts suggest sophistication regarding the uncertain qualities of treatment and the implications for HIV prevention coupled with the rise of doubt and insecurity in intimate relations. Moreover, they point to the negotiated aspects of risk management in sexual practice with other HIV positive partners. However, doubt was not always an issue:

It was something we both agreed on. Because we’re both positive we just believed that, we know there’s a lot of risks with two guys having different strains, we understood all that before we decided to stop using condoms ... [later] ... besides the fact, ‘coz we’ve been having sex for so long without condoms, his strain, would already be in my system anyway, so it’s not going to make any fucking difference. It might change my outlook on new relationships, but as far as [my boyfriend] goes, no ... (George: 1).

In this depiction, George and his boyfriend were not doubtful and in any case they were also able to assume that reinfection had probably already happened, producing a kind of viral equivalence. However, taken together, the accounts indicate that insecurity may arise in sexual relations for gay men with HIV if there is no happy coincidence of risk management preferences.

There is an important irony in enduring doubt about reinfection risk. Recent analysis has considered that treatment is risk producing because it creates optimism about the future (Elford et al., 2002; Kelly et al., 1998; van de Ven et al., 2000). In a sense this notion of

optimism is quite cynical. It assumes that instrumental scientific progress such as the advent of treatable HIV is associated with unwanted effects such as increases in unsafe sex. However, the mixing of paradigmatic and post-paradigmatic HIV subjectivities revealed in these accounts suggest that treatment-related risk is experienced in a different way. A more appropriate depiction would be the importance of the negotiation of personal preferences in the situation of uncertainty and contest concerning expert knowledge and for some, doubt and therefore insecurity in their sexual partnerships with other men with HIV.

The various interpretations of reinfection risk also foreground a kind of cooperative reflexivity of sexual relations that echoes the discussion of the prevention imperative in the previous chapter. Risk management is necessarily negotiated and relational. A method for managing risks such as reinfection cannot be achieved in sexual practice without reference to some sort of consensus of personal preferences and expert deliberations. By extension, there is then a possible limitation on the relevance of an idealised form of the reflexive, individuated self of late modernity. The idea of reinfection is a contestable risk consideration, something that sponsors a question of preference. Reinfection also implies sameness and difference and therefore mobilises a symbolic world of virological sociality informed by a universalising epidemic 'narrative' which supplies a method for constructing sexual risk relations in a time. However, the contestable qualities of reinfection fold back into sexual relations to create doubt and insecurity when 'preferences' do not coincide or when one is unsure about which position to take. In a sense, cooperation is required to agree a suitable method and to reduce insecurity. This potential unease in sexual relations may be a leitmotif of post-crisis risk governance. The advent of treatable HIV and the kinds of uncertainties and contests of knowledge it inspires, has to be addressed with the effective

combination of personal preference and cooperation in sexual relations.

Undetectable viral load

This section addresses knowledge of viral load and interpretations of infectiousness. ‘Undetectable’ is the term applied to the measure of viral load below the threshold of detectability using current monitoring technologies (AIDSmap, 2003). Undetectable viral load is the benchmark of viral suppression and is a key treatment goal. But low viral load also has implications for the potential for transmission of HIV in sex. It has been proposed that knowledge of their own undetectable viral load might give people an impression that they are no longer able to transmit HIV and therefore may lead them to abandon condoms. However, no interviewee held that safer sex was unnecessary because of low viral load. As with reinfection, the accounts suggest absolute and relative perspectives were important to interpretations of viral load and infectiousness. However, a reversal related to HIV serostatus of the sexual partner was apparent. The paradigmatic construction of reinfection risk, “... HIV is HIV”, was a justification for making safer sex unnecessary between men with HIV infection. But in connection with viral load and infectiousness, an absolute ordering of risk justified safer sex with HIV negative men. However, relativism had use in that it conferred improved security. Either in terms of health or transmission of HIV to their HIV negative (or unknown status) sexual partners, low viral load afforded risk reduction and therefore reduced anxiety about HIV transmission. There was also a sense of the active interpretation and use of medical knowledge and services to help reduce the risks of HIV transmission and to moderate anxiety about such risk. The interviews contribute to a more diversified and extensive depiction of risk management than usually implied in extant policy and research. Mainstream public health argues for interrupting any sense of the risk reducing aspects of HIV medicine in sexual practice to: “... promote norms of

responsibility and protection of others in sexual matters” and “... foster the perception that HIV is still a life-threatening disease despite medical advances in treating it” (Marks et al., 1999: 303). The accounts discussed in this section subvert this logic and suggest that HIV medicine in its larger sense is a form of expertise and institutional resource that has a role to play in the reduction of HIV risk and the amelioration of threats to security in sexual relations. This discussion is separated into three parts. First, I explore absolute and relative perspectives on viral load and infectiousness. In the following part of the discussion, I address how a sense of reduced infectiousness does not make safer sex unnecessary for interviewees, but that it does provide a source of security if risky sex does happen. In the last part of the discussion, I contrast accounts of professional advice about infectiousness that suggest that uncertainty and contest about medical risk knowledge also frame the HIV prevention work of the treatment clinic.

Variable virus or “... a virus is a virus”

Interviewees seemed to accept the idea that HIV treatment was able to manipulate viral activity, expressed in measures of viral load. In the next two examples, the first introduced at the beginning of the chapter, the interviewees refer to variation in HIV infection connected with treatment:

... there’s no kind of, you’re either infected or you’re not, there is a huge degree of, you know, you can be very badly infected, you can be a bit infected, and if you alter that ratio, I mean, the drugs alter it so that you’re only a bit infected ...
(Stephen: 2).

MD: The final thing around risk stuff is undetectable viral load, what do you think that means in terms of HIV?

Peter: I think you just can’t see it. I think it lurks there, I don’t think it’s gone

away, I think, you know, wack! If I come off the drugs it's going to shoot back up, and I think'til we know more about what is going on, and I think it's still very early stages, or a vaccination cure, you know, it's a word: It's 'undetectable' (1).

Both these examples confirm a link between treatment effects and viral variation. But at the same time, there was no sense that HIV was eradicated. In particular, "Lurk" described infection limited (but not eradicated) by treatment. "Undetectable" was not important for HIV prevention because treatment only contained the virus. It appeared that the effectiveness of treatment combined with assessments of viral load gave rise to the notion of a variable, manipulable virus, which was nevertheless present. 'Weakness' or undetectable was also recognised as provisional:

... your undetectable viral load is only as good as your last blood test, you know, and that could change at any time ... (David: 1),

The fact it doesn't show up on a test doesn't mean, OK your viral load might be one but it's still there. I mean if we find a cure for it and you can sort of obliterate it completely then you know maybe, then maybe it's OK. I don't know. But at the moment all it means is that the test isn't sensitive enough to show the HIV, that's my belief (Robert: 1).

These accounts suggested an awareness of the changeability of blood test results or that the testing technology itself was seen to be limited in terms of sensitivity. In the absence of "cure" or the capacity to "obliterate", low HIV viral load test results represent the effectiveness of treatment but they also betray the temporarily contained, but enduring, virus. In this sense, constructions like "undetectable" have a double meaning in that they

signify desired treatment effects but that they also suggest virus existing beyond the acuity and efficacy of testing and treatment technology.

As with reinfection, interviewees were divided about viral load and HIV transmission or ‘infectiousness’. Some said they believed that HIV transmission was possible but that the risk had attenuated:

I think by having my viral load as low as it is I am not as infectious, but I’m still infectious. So it’s just, it is, you know, yes, I’m putting somebody at less risk ...
(Vincent: 1),

... I’m still infectious ... I would presume to a lesser extent than I was before, but still nonetheless presumably infectious ... (Michael: 1),

Colin: I was part of the control group because I didn't have gonorrhoea [laughs] and he [the doctor] came back and said: ‘We can't find any virus in your semen or sperm’ ... I see myself as about infective as a squashed tomato, that's how I see myself.

MD: So you don't see that you could pass on HIV?

Colin: I didn't say it was impossible but I think it's a very, very slim chance. That's what I would like to think anyway (1).

These quotations reveal different engagements with the idea of the risk reducing qualities of undetectable viral load. Interviewees seemed to recognise that lower viral load and therefore treatment, reduced infectiousness. But the interviewees also held that it was still possible for them to transmit HIV to another person. These accounts therefore reveal an engagement with the attenuation of HIV transmission risk connected with treatment, suggesting also an engagement with a post-paradigmatic ordering of risk

calculus.

Conversely, as with reinfection risk, an absolute point of view was also possible. In the next example, the interviewee mobilises a paradigmatic notion of HIV risk:

Rodney: ... but touch wood my strain seems to be quite weak. I mean that's just my guess because I've had no symptoms for so long

[Later]

MD, So, knowing about that your virus may be not a very strong one, so it's kind of weak.

Rodney: Well, that's my guess. But it's still there, you know.

MD: Does that change your ideas about how infectious you might be to another man for HIV?

Rodney: No, no it doesn't. To be honest, the business about my virus being weak is something which I've never actually said aloud before to anyone. It's been in the back there and maybe this conversation's brought it up, but a virus is a virus no matter how potent it is, you know (1).

"A virus is a virus" resonated with the notion of "HIV is HIV" discussed in the last section. In this view, treatment is understood to reduce viral load, but not in a way that disrupted the categorical HIV infection and its implications for prevention. This position on viral load and infectiousness was connected with a rejection of reduced risk of HIV transmission in sexual practice:

Complete codswallop. I mean that's sort of delusion isn't it? You're saying the viral load is so low that even if body fluid passes you know there's so little of this whatever HIV in it that, so what? Even if there's a tiny bit in it maybe it takes a bit longer to grow [pause] It's complete self-delusion. It's just another way of excusing

having unsafe sex as well. I don't believe it. I mean, I practise unsafe sex but I've never deluded myself with any of these arguments whatsoever ... I take the view that any sort of unsafe sex is risky ... (Tony: 1).

In this example, the interviewee rejects the idea that low viral load moderates infectiousness and therefore, shuns relativism. This position represents an important reversal concerning the risk implications of absolute and relative risk. 'HIV is HIV' was the basic paradigmatic assumption that underpinned the sense that reinfection was not a significant health risk between men with HIV. But in the previous account, an absolute and therefore paradigmatic position provides the basis for a negation of the idea of reduced infectiousness related to viral load. This reversal reveals the importance of the HIV serostatus of the sexual partner. Between HIV positive men, absolutism is connected with the lack of use of condoms: relativism mobilises the need for precautions. Between a HIV positive man and a HIV negative man, absolutism predicates the need for condoms: relativism suggests reduced infectiousness. The superordinate importance of serostatus reflects the HIV prevention imperative and the risk relationship discussed in chapter three (Lather, 1995). The use of the term "self-delusion" also suggested that the notion of lower infectiousness was a rationalisation of self-interested people with HIV:

I've obviously read an awful lot and I tend to believe more what I read. You know, unless proven otherwise then unsafe sex is unsafe sex. There's no sort of qualifying it with these other possibilities (Tony: 1).

Relativistic interpretations of HIV transmission risk were rejected. The idea that "... unsafe sex is unsafe sex" was also suggestive of the imperative of HIV prevention. Similar views about the relative risk of HIV transmission in various sexual practices were

also “cop-outs”:

... and all of these sort of cop-outs, I've got a low viral load or I'm the active or I'm the passive one, I didn't cum inside you. You know, all these sort of standard cop-outs [Later] you might as well say the guy looks healthy therefore not very high risk or the guy looks like a beanpole then he is high risk. It's that sort of rather crude way of looking at things ... (Tony: 1).

In this account, the idea of reduced infectiousness was relegated to the category of the other excuses made for having unsafe sex. Several of the other interviewees shared this absolute position on viral load and infectiousness:

I still think I'm infectious as I was when I had a viral count of millions (William: 2),

I always assume, I behave as though, it doesn't reduce the chances (Thomas: 2),

I don't assume that 'cause I've got a low viral load that I can screw people without risking them (Kevin: 1),

You've still got HIV, you're still positive, and you're still carrying the virus, doesn't mean to say they've killed it off (Timothy: 1).

So as with the idea of reinfection risk, the interviewees were seen to choose between either risk relativism or absolutism in connection with viral load. It seemed that interviewees chose a risk management approach that made them ‘comfortable’. The interviewees were also reflexive with the idea that their preferences were a matter of personal choice. In this example, the interviewee makes reference to the idea of an

individualised risk management position:

MD: Do you think a positive man with undetectable viral load is less infectious than ...?

Peter: No, I don't actually. No ...

MD: 'Coz some people are saying that it is like you are less infectious ...

Peter: Well, that's up to them, but it's not how I think (1).

This interpretation of infectiousness makes a stark division between personal position and those of others. "That's up to them" and "... it's not how I think" suggested how risk position was actively adopted by a volitional subject, rather than installed as a matter of technical knowledge.

The idea that one has to adopt a position in relation to post-crisis risk may be intelligible in terms of the idea of individualisation in reflexive modernisation (Beck & Beck-Gernsheim, 2002; Giddens, 1991). Although they do not refer to reflexive modernisation, analysts in the area of HIV have argued for the emergence of individualised or "... individually tailored" risk management approaches (Rosengarten et al., 2001: 4). These perspectives give rise to the idea of risk management as 'bespoke', something that connotes individualism and consumer choice in risk reflexivity. But the mixing of treatment, risk and individualism undertaken by the interviewees suggests that risk reflexivity has to do with preference for managing the ethical dilemma that arises in the situation of uncertainty and contest. "Well, that's up to them, but it's not how I think" suggested that taking up different positions on HIV risk was an ethical consideration. In other contexts in this thesis, I have drawn attention to the valorisation and contradictions of free agency in risk management. Returning to the discussion of risk management responsibility in chapter six, interviewees were reflexive

with the idea, and moral quality, of personal choice about risk management:

... If that's what you're doing [unsafe sex], keep it to yourself, you know. It's your life, you do as you please with it, you know, if you want to kill yourself. fine I won't be made to feel as though it's my problem when it's their actual doing, you know. 'Coz we all have choices in life. So if they choose to do that, it's their choice, not mine ... (George: 1).

In chapter five, in connection with life expectations and self-care, I discussed how responsibility and individualism emerged in the post-crisis mingling of sexual practice and treatment options:

... it's really sad, from my point of view, they think because now we've got really good drugs they're going to play with that. For me it's so ignorant the people that are advertising on the Internet for better sex. If that's what they want to have, fantastic, go ahead and do it. Do with your life what you want, enjoy it as you like. I'll make sure I get my life on the decent path. Everyone's got a different way of seeing things ... (Ronald: 1).

Together with the present analysis of treatment-related knowledge and HIV prevention, we can infer that the idea of individual choice permeates risk management. Adkins has argued that risk reflexivity is a method of governance not an effect of risk society (Adkins, 2002). Adkins suggests that the individualising aspects of risk reflexivity mesh with the neo-liberal project of furthering entrepreneurial action. Constructions like: "Well, that's up to them, but it's not how I think", "So if they choose to do that, it's their choice, not mine", "Everyone's got a different way of seeing things" do seem to suggest a valorisation of individualism of a neo-liberal kind. Applying Adkins's perspective to the current topic, it may also be that personal preference facilitates the

use of treatment with the properties of manufactured uncertainty. Without an arrangement of preference in risk management, the use of such uncertain and contestable technologies would be compromised and perhaps unacceptable. For example, in chapter five, I discussed how embarking on treatment was constructed as a difficult, but nevertheless, personal choice. The utility of personal preference appears to permeate risk calculus about treatment, but, as the interviewees suggest, is also salient in matters of sexual relations. It may be that preference also has significance because of the intersection of treatment-related risk and sexual practice. Risk management preference may not simply hinge off the proliferation of uncertainties in technical knowledge and contests that arise in the situation of treatable HIV. Risk management preference may also have to do with how sexual relations are organised as a matter of the free action of the desiring, individualised subject. In this way the politics of uncertainty and desire are brought together in risk management preference, an alliance that may further a neo-liberal governance of treatment and its implications for sexual practice.

Security and sex with HIV negative or untested men

The analysis suggests that variable viral load was not seen as a justification for setting aside safer sex. But it did seem to provide a source of comfort or security. Interviewees provided accounts of how they had used information like undetectable viral load, or in a broader sense, viral variation, in the ongoing management of risk in their sexual relationships with other HIV negative or untested men.

As with the idea of reinfection, sameness emerged as a theme in interviews about viral load and infectiousness. For example: "... he says he does sometimes think it would be easier if we were both positive" (Michael: 2); "... it's so much easier. There's no hang-

ups, there's no fucking worrying. There's just life when you're with a positive guy, they know the risk better than anybody" (George: 2). The sexual combination of people with the same risk identity seems easier to live with. Conversely, sexual practice with a HIV negative man was suffused with anxiety. For example, in general having a HIV negative partner created significant risk management concerns:

I suspect between two people who are negative, and get tested regularly and don't fool around, that [risk management] may be different if I weren't HIV positive I wouldn't be here, but if I had a boyfriend and we knew we were both negative we probably wouldn't be nearly so careful ... (Stephen: 2).

This account suggests that men in partnerships with HIV negative men place additional emphasis on HIV transmission risk. In this situation, low viral load provided 'comfort':

... now I gather viral load is also a measure of infectivity and it doesn't mean oh goody, goody, I can take more risks. It just means I believe they're related, which is quite a comforting thought. So if it's lower, then I'm less likely to infect somebody it's comforting to know that I'm less likely to do it. That what I'm passing on is likely to be fought off better. I mean I don't know, I've no intention of passing it on to anybody. But it's just, you know, it's a comforting thought really, isn't it? (Stephen: 2).

This account suggests both attenuated virus and improved security. "Comforting thought" underlines the role HIV treatment has to play in the promotion of security in sexual relating with HIV negative men. It also seemed that changes in viral load were a focus for anxiety concerning HIV transmission in a sexual partnership with a HIV negative man:

... my viral load had gone up from undetectable which it had been undetectable

for three years to 1.8 million or something and my CD4 count had dropped from 590 to 60 all in the period of two weeks. That put a stop to the unsafe sex funnily enough ... [later] ... he tested just after we got back from holiday the last time and after I'd had the rebound [increase in viral load] and he was negative (Michael: 2).

This account gives the impression that changes in viral load influenced the sexual practice of the narrator and his partner. Change in the viral load of the narrator also appears to be associated with HIV antibody testing on the part of the HIV negative partner. The depiction gives the impression that aspects of HIV medicine can be used to define risk in sexual practice (viral load) and to assuage anxiety about HIV infection (antibody testing). There is also a suggestion of other uses of HIV treatment in risk management. For example, post exposure prophylaxis for sexual exposure (PEPSE), figured in this account:

... [he] went for a check-up and to tell the doctors that he'd had active unsafe sex, anal intercourse with me, and told them that I had a couple of hundred T cells, I think and undetectable viral load, and they put him immediately on three months PEP ... (Michael: 1).

These accounts suggest an engagement with HIV medicine, and through it, the various methods of risk reduction it affords in and around sex. Perhaps for these reasons, knowledge associated with viral load measures was mingled into the ongoing security of the sexual partnership:

It's really difficult because for as much as I don't want to put him at risk, when he's there and he's, I can see that he wants to fuck me, I want him to. And I come up with these excuses that well it's his responsibility and he's, you know, he

knows what he's doing, and look I haven't had any detectable viral load for two years now, and I'm probably really healthy and it probably wouldn't be infecting him, it's probably just a tiny, tiny, tiny margin that he'd be infected, and it'll be okay really, and God it feels good, go on, and, it becomes very difficult because at the same time I want to say: 'Stop and just put a condom on', and which is what I do. And every time, it's one of those when I say: 'No, stop, put a condom on', my head is saying to me: 'No just let him' (Michael: 1).

This account refers to struggles with the use of condoms for anal sex intermingled with risk knowledge. In particular the idea of undetectable viral load appears as a form of moderation of risk and anxiety. Yet another form of risk management was using the HIV clinic to seek out advice:

... like last week I cut myself and he got blood all over him. But he did come and have a check with one of the nurses and they sort of didn't seem to think that he had anything to worry about 'coz he didn't have any deep cuts anywhere where the blood had gone on his skin (Edgar: 2).

HIV clinical care and treatment seem to be important sources of information and intervention regarding HIV transmission risk in sex with HIV negative regular partners and otherwise. Knowledge about viral load and related technologies were methods of reducing anxiety and improving security. In particular, the idea of 'undetectable' viral load was revealed to reduce the risk of HIV transmission and therefore to improve confidence in sexual relations. This is a different meaning of treatment and risk behaviour than that of notions like treatment optimism. Treatment-related knowledge does not seem to facilitate unsafe sex, but it has value in counteracting the 'juggernaut' and furthering security in erotic relations. In this sense the risk management potential of

HIV treatment in sexual practice parallels its capacity in improving health and therefore its connotations for ontological security in general.

There was also some suggestion that the notion of reduced infectiousness was attractive for men because it created the prospect of the alleviation of the negative aspects of HIV positive identity. In the following account, the interviewee discusses the idea of losing his HIV positive identity through treatment and related monitoring of viral load:

MD: So viral load and infectivity are linked for you? Is that, at some level it seems like they are?

Michael: At some level, yes it is. Logically I know that just because when they take a small blood sample they can't find it in that blood sample doesn't mean that it's not going to be passed on to him. But the fact is that, you know, there's that part of me that wants to believe that I'm HIV negative now. And that's what it comes down to. When, if they can't find any HIV in a blood sample then I don't have it. And it's a kind of, a form of denial I suppose in some ways, it's like I'm cured I know, intellectually, that that really isn't the case yet (1).

Reduced viral load conferred the possibility of "cure" and removed or lessened the effects of the status of 'HIV infected'. However, the interviewee is reflexive with the proposition that treatment has the capacity to cure. The account reveals that, via treatment, a different way of living with HIV can be imagined.

Treatment-related knowledge was also relevant where risky sex occurred with a casual partner. This interviewee provides a depiction of a risky sex episode:

At first I got a bit panicky. And then I thought if I carry on being panicky I'm just going to lose my erection and that's going to be the end of this and I was really quite

enjoying it. I didn't come inside of him. I refuse, when somebody jumps on my cock like that I refuse point blank to come inside of them. Although I've had a test done and they can't find any HIV in my sperm, or seen them allegedly. But I still refuse to cum inside of people (Colin: 1).

“They can't find any HIV in my sperm” represented the application of medical knowledge to HIV prevention. This knowledge had the effect of mitigating both risk and perhaps blame. This is a dynamic that does resemble the notion of how treatment optimism influences sexual risk behaviour. The interviewee applied knowledge about viral load to create an assessment of reduced risk. But we can also see that the interviewee figured himself as passive in the encounter, mitigating against a negative judgement of responsibility. Here is another example:

Malcolm: ... the other thing I was going to say whether I see HIV as not quite so much, you know, an instant killer deadly virus sort of thing which has made me feel a bit more relaxed about penetrative sex, I still think one should always use a condom. But there have been a couple of times recently where, people have just, I don't know, for the want of a better word sat on me sort of thing.

MD: Without a condom?

Malcolm: Yeah, and you think: ‘God this person is really stupid’, and well I wouldn't sort of take it any further, but I haven't felt: ‘God I've done that, they must now be, you know, infected’. I've never, I wouldn't cum or actually, sort of carry on and think: ‘Oh I'll stop before I'm going to cum’ (2).

It seems that treatment and its effects make risky events easier to live with. Sexual actors find that they could be more “relaxed” if risky sex occurs. But it was not the case that safer sex was ruled out. Knowledge like infectiousness and viral load has a mitigating

property because it reduces the anxieties that arise in sex that becomes risky. Treatment-related knowledge therefore also has value as a kind of sexual security in casual situations. This connection between risky sex and the value of treatment resembles the theorised link between treatment optimism and HIV prevention practice. But there is an important difference. In these accounts it is not that treatment optimism leads to sex without condoms. The risk moderation value of HIV treatment is seen to emerge after penetration has occurred. Moreover the interviewees constructed themselves as passive even when penetrating, creating questions about the responsible conduct of their sexual partners. 'Active' penetration without condoms was not discussed, suggesting that HIV positive men avoid it, or that it was too difficult to discuss.

The ambivalent clinic

I have argued that both absolute and relative constructs of risk were important to interpretations of viral load. Absolute and relative perspectives on risk were also discernible in accounts of expert advice. The next examples provide a salient contrast. In this account, already discussed in connection with viral load, the interviewee refers to being provided with knowledge that, presumably because of treatment, his semen contained no HIV, implying reduced infectiousness:

Colin: I was part of the control group because I didn't have gonorrhoea (laughs) and he came back and said we can't find any virus in your semen or sperm. I was quite shocked actually by that but I have read things in the papers and magazines over the years of being just left in the spleen and the tonsils. So why not just have one's spleen and tonsils out and be done with it!

[later]

MD: And you know undetectable virus, you talked about semen as well, how do you see yourself undetectable?

Colin: I see myself as about infective as a squashed tomato, that's how I see myself.

MD: So you don't see that you could pass on HIV?

Colin: I didn't say it was impossible but I think it's very, very slim the chance. That's what I would like to think anyway.

MD: Because of undetectable viral load and the combination therapy...

Colin: Undetectable viral load and no virus in my semen (1).

In the next account, the interviewee also refers to being provided with advice. In this instance however, the interviewee suggests that treatment does not necessarily reduce infectiousness:

... from speaking to [my doctor] and from my own reading around the subject it seems that a low viral load in your blood system is no guarantee that there's no HIV in your semen or that there's a similarly low reading of HIV there. And my understanding also is that even if the drugs penetrate your blood stream so as to suppress HIV there that it can be in all sorts of other places, like your brain and lymphatic system. So I don't assume that 'cause I've got a low viral load that I can screw people without risking them I don't think (Kevin: 1).

The contrast of these accounts suggests several aspects of risk knowledge connected with HIV treatment. It appears that the provision of risk advice may not be uniform. The contrast between these accounts also suggests that treatment effects on infectiousness is itself leading to multiplicity: a situation of different bodies with different biomedical characteristics and therefore different implications for risk of HIV transmission in sex. This opposition also allows a connection with the risk society perspective. It may be the case that differing assessments of reduced infectiousness are true effects. Risk of HIV

infection seems to be associated with increased viral load, although the implications of such findings remain contentious (King, 1998; NAM, 2002b; Quinn et al., 2000). The interviewees however, take contradictory positions based on what they refer to as expert advice. Some men spoke of being informed that they were less infectious, while others said they had been informed they were not. We can speculate that medical experts relayed information of true effects. We can also consider that medical experts vary with regard to whether their patients should be told about the risk implications of low or undetectable viral load. Or perhaps medical experts are subject to a similar dilemma of taking up risk management positions in the face of the uncertainties and contests of risk knowledge that arise in HIV medicine. These contradictions suggest an ethical problem for the practice of medicine itself in the situation of uncertainty and contested risk knowledge.

As with reinfection, where doubt about a paradigmatic position about risk led into insecurity, the notion of low viral load and reduced infectiousness could also be problematic:

Yes if you're an undetectable level what does that mean? How undetectable is undetectable? How little HIV do you need in order to infect somebody else? Keep having to say don't know at the moment (John: 1).

“At the moment” suggested reflexivity with likely future changes in advice about such issues. For other men, advice from different sources led to confusion or contradictory beliefs about the virus in their bodies and HIV transmission:

I'm a bit confused about that and the reason that I'm confused at the moment is because of a remark made to me by [my doctor] some weeks back, some months back in fact, probably the last time I challenged him about or asked him, I won't say challenged, when I've actually raised my sexual behaviour as an issue during that

kind of clinical session He said that I was more, I had more chance of passing on hepatitis B than I did of passing on HIV given the low detectable, the undetectable level of my viral load I walk about with those words reverberating in my head, not knowing whether I can believe them or not I've no idea because my medical knowledge isn't developed enough to know (Alastair: 1).

This account refers to a doubting narrator, reflecting on expert advice, but left in a precarious situation. “Not knowing whether I can believe them or not” suggested contested knowledge but also a sense that the interviewee was unsure if he had ‘permission’ to have such ideas. It seems possible to argue that advice that arises in HIV consultations is also subject to uncertainty and contest.

As with reinfection, the interviewees suggested the importance of preference for either absolute or relative constructions of risk in the circumstances of contestable knowledge about viral load and infectiousness. There were also points of continuity between reinfection risk and viral load risk in terms of security in sexual relations. But there was also an important reversal in relation to the HIV serostatus of the sexual partner. For reinfection, an absolute, singular form of HIV obviated the need for safer sex with another HIV positive man. The absolute assumption about viral load risk was a reason for safer sex with a HIV negative or untested man, and was used to oppose the “cop-out” notion of reduced infectiousness (Tony: 1). However, for some, low viral load did appear to provide a source of security in sexual partnerships and or when unsafe sex did happen, a feature of the treatment experience that is not often acknowledged. The interviews also suggested a widened engagement with the risk management capacities of HIV medicine to resolve the unexpected HIV risks of ongoing sexual partnerships. It

also seemed that, either contested knowledge about infectiousness or the prospect of an actual biomedical individualisation of infectiousness, led to an ethical problem for medical interventions that emanate from the clinic. In this sense, gay men with HIV are joined by their carers in the post-crisis domain of a politicisation of preference in the circumstances of uncertainty and contested knowledges about risk.

Summary

This chapter has developed an argument that in the post-crisis situation, the achievement of the HIV prevention imperative is mediated by the preferences of reflexive actors engaged with the ethical implications of uncertainty and knowledge contest. In the post-crisis situation, safer sex is not necessarily less important for gay men with HIV. But HIV medical technologies such as the anti-body blood test, genotyping and viral load are considered in efforts to reduce viral and social risks and further security in sexual relating. However, reflexivity concerning post-crisis forms of risk knowledge is necessarily expressed as a matter of preference. Post-crisis actors are required to opt for either a letting in of variable HIV, or, refusing it. These absolute and relative perspectives on risk knowledge intersect with, but do not displace, the importance of the risk relationship, or in other words, the HIV serostatus of the sexual partner. The accounts therefore suggest an alternative to the orthodox way of thinking about treatment and HIV prevention practice. The analysis suggests the cultural organisation of embodied sexual agents, where treatment-related knowledge about risk is combined with sero-identity to help structure the risk relationship. HIV prevention has to do with how sexual agents position themselves (physically and symbolically) in sexual encounters informed by technical risk considerations, the serostatus of the sexual partner (if known), ethical stance on HIV prevention in conditions of uncertainty and contest, and the achievement of security in sexual relating. In place of the idea that

optimism undermines HIV prevention, this analysis suggests that some post-crisis concerns for gay men with HIV are enduring doubt about some methods of HIV prevention in sexual relations and identity-related blame for HIV transmission.

CHAPTER EIGHT: CONCLUSION

Introduction

This research addressed the implications for gay men with HIV that arise out of the paradoxical notion that effective treatment for AIDS can be a reason for the proliferation of HIV. I used qualitative interviews to address a gap in how we understand this post-crisis situation for gay men with HIV and to contribute to the development of theory about the links between treating and preventing HIV. I used three problematics to achieve these aims. In particular, the interviews explored the meanings of post-crisis relevant to gay men with HIV. The thesis also made a relationship between innovation and imperative as a way of developing an account of reflexivity in connection with treating and preventing HIV. And the relevance of treatment-related knowledge for HIV prevention in sexual practice was addressed using the risk society themes of uncertainty and contest. In this concluding chapter, I first reflect on what these three problematics contribute to the development of a grounded and theorised account of the post-crisis experience of gay men with HIV. Second, I discuss these perspectives with reference to the relevant literature, critiquing and extending some of the usual assumptions and conceptual frameworks of the post-crisis situation. The final section makes some comments about knowledge claims in a changing epidemic.

Reflecting on contribution to knowledge

This thesis has made an argument that the idea of post-crisis forms a system of regulation because it inspires a focus on change, changed identities and risk conduct. I elaborated on the idea of reflexive treatment to open up perspectives on self-construction in post-crisis as a matter of the surveillance properties of aspects of

medical technology. I also adopted a critical stance about knowledge and knowledge-making in connection with post-crisis. A major theme of scientific inquiry in post-crisis relies on a simple notion of treatment optimism and its connection with risky sex. This science is normally practised using notions of rationalistic health behaviour and quantitative methods. In addition there is far less attention to alternative explanations of risk practice and dialogical qualitative methods. In this regard, the science of post-crisis has the effect of limiting how we can understand aspects of the post-crisis experience and in particular, the connections between treatment and prevention. This is an important negation since the identities and practices of gay men with HIV are under scrutiny in post-crisis. In contrast, I have used an iterative qualitative methodology to help encourage the flooding in of meaning, to open to view the various struggles with identity of the post-crisis situation and engage with the difficult aspects of uncertainties and contestable knowledge. The following discussion reflects on the three problematics used to develop this thesis. First, I discuss how the meanings derived from the interview accounts can be conceptualised in terms of their meeting points and contradictions, or in other terms, the interfaces of different understandings of the post-crisis experience. Second, I will draw attention to one interface in particular: the idea that treating and preventing HIV involves both innovation and imperative, and sponsors engagements with mutable identities, required action and resistance. Finally, I identify how preference emerged as a necessary method for dealing with the uncertainties and contests of aspects of HIV treatment.

The interfaces of post-crisis meanings

The interview accounts suggested that post-crisis was an ambivalent experience. Further, the meanings of post-crisis are constructed through the contact points and contradictions of the different regimes of knowledge about it. For example the

interviewees expressed both hope and uncertainty about living with HIV treatment. The post-crisis experience also appears to be one of personalised threats to security and implications for self-care co-existing with invisibility and public complacency.

A theme of the accounts was the contradiction between turnaround in life expectations and being given limited prognoses in clinical care. It seems that gay men with HIV are encouraged to think of HIV infection as a treatable, chronic condition based on a generalised sense of the achievements of medicine. But at the same time, life expectations are undermined by the short prognoses derived from the calculations of medicine. In these paradoxical circumstances, uncertainty was found to have a novel use as a way of resisting calculation and therefore limited prognosis. It was the case that the interviewees found uncertainty related to treatment expectations to be difficult. But uncertainty was also a source of hope for prevailing despite predictions to the contrary. This interface of the different positive and negative meanings of uncertainty informed methods of self-care in post-crisis. Interviewees were interested in a kind of 'stocking up' of both the resources of the self and medicine so that they could extend the benefits of treatment. They were therefore interested in a kind of surplus of the positive value of uncertainty as a way of sustaining a reflexive life project.

The accounts also gave rise to a sense of the different and changing visibilities of AIDS and HIV associated with a personal/public division. AIDS in general was seen to have become a lesser force in the cultural construction of risk and as a matter of personal experience. HIV has also become less public through a requirement of making it less visible, but it therein endures as a more personal, ramified concern. HIV is further divided so that control of the virus becomes a medical problem, while the other, less determinate aspects of health and well-being are also personalised. Post-crisis is

therefore experienced as a change in the mutually dependent meanings of AIDS and HIV. This perspective gives rise to the prospect of public complacency about HIV risk, but enduring and proliferating private insecurity.

Innovation, imperative and identity

Along with these different meanings of post-crisis, the accounts also revealed the various implications for identity connected with treatment innovations and prevention imperatives. Post-crisis is experienced as an engagement with a mutable self with HIV, the requirement of HIV prevention and the mingling and clashing of these notions. For example, "... shagged by another virus" (Edgar: 2) brought together the post-crisis innovation of mutable HIV identity and the imperative of prevention. The prevention imperative describes the need for altruistic action on the part of the person with HIV in relation to HIV transmission. But the imperative imbues the identity of the person with HIV with the meaning of source of danger, conferring responsibility and blame. The interviewees were therefore focused on avoiding both HIV transmission and the negative aspects of the imperative of HIV prevention. Risk management was therefore more than control of HIV transmission. It included managing one's identity in relation to negative judgements about conduct. Because of these implied threats to identity, risk management in sexual relations was depicted as an adaptation and mingling of altruism with self-protection. For instance, an adapted altruism was useful as a form of self-protection when risky sex happened, because it moderated blame and related negative emotions.

Uncertainty, contest and preference

Based on the perspective of different meanings of the post-crisis experience and the mixing of innovation and imperative, the thesis explored how knowledge related to

treatment monitoring technologies was taken into HIV prevention. It argued that because treatment knowledge is uncertain and open to contest, it creates a challenge of choosing a position with reference to considerations that exceed the technical. This argument was made in connection with how the interviewees approached the ideas of reinfection and infectiousness, both of which are examples of aspects of HIV treatment that have implications for sexual practice. Treatment-related risk concerns were also referred to the serostatus of the sexual partner, suggesting that HIV serostatus and therefore the risk relationship, remains a central consideration for gay men with HIV. However, the interviewees subscribed to either absolute or relative forms of risk calculus as a matter of preference, revealing the circulation of both paradigmatic and post-paradigmatic forms of risk calculus. The paradigmatic in HIV prevention referred to an absolute sense of HIV risk articulated around the categorical HIV positive identity. The post-paradigmatic was opened to HIV varied in terms of amount and type by the action of treatment. In the post-crisis situation, gay men with HIV are required to take up a position in connection with the contests over the provisional character of expert knowledge. This is a kind of precarious freedom made in the joining of medical technology and sexual relations.

Critiquing post-crisis assumptions

The perspectives on meaning, identity and contest established in this thesis provide several ways of critiquing post-crisis assumptions. In particular, the thesis establishes the idea of reflexive treatment as a way of legitimising an alternative way of thinking about the post-crisis situation. The normative view of post-crisis is that it is something that happens after treatment is taken into bodies, suggesting passive bodies reconstituted by treatment and conferring on treatment a kind of agency of its own. Conversely the reflexive view suggests that the treatment of HIV is achieved by active, knowledgeable

subjects. By extension, HIV prevention, and its intersection with treatment in the post-crisis situation, is also mobilised by active subjects. This reflexive view has several implications for critiquing and extending how we conceptualise HIV prevention in the post-crisis situation. It suggests the importance of the alternative meanings of post-crisis evident in the accounts of gay men with HIV. It identifies the positive value of uncertainty in the reflexive life projects of gay men with HIV and suggests some implications for social care connected with the paradoxical qualities of public complacency and private insecurity. The reflexive view also provides a critique of treatment-optimism orthodoxy and draws attention to the methods used by gay men with HIV to manage the HIV prevention imperative attached to HIV serostatus.

Post-crisis alterity

The analysis suggested some of the other ways of accounting for the post-crisis experience. It provides a basis for challenging the idea that the advent of treatable HIV is simply a definite medical watershed in the history of the epidemic. This challenge is evident in terms of the different personal accounts of the experience of the advent of treatable HIV, the tempering of hope and questions for ontological security.

Post-crisis is conventionally understood as a medically-constituted era of chronic manageable disease and the normalisation of the health of people with HIV connected with the advent of effective HIV treatment (Greene & Ward, 2002; Rosenbrock et al., 2000; Siegel & Lekas, 2002). In contrast, and building on HIV illness narrative research (Pierret, 2001; Roth & Nelson, 1997), the analysis suggested the diversity of narrative engagements with the advent of treatable HIV. With reference to the critical perspectives that have been developed in HIV illness narrative research (Bartos & McDonald, 2000; Ezzy, 2000) and post-structural perspectives on life stories (Plummer,

1995; Simon, 1996), I argued that turnaround narrative did have relevance for interviewees who had expected to die. But it was not the only possible way of narrating the post-crisis experience. In particular, I suggested that turnaround coexisted with liminality, the body-blow and prophecy. These different narratives suggest that post-crisis is not a singular experience.

This research extends the literature about living with HIV in an important way connected with the notion of ontological health. The few publications in the field concerning accounts of lived experience after the advent of treatable HIV suggest that treatment-related uncertainties remain a problem for people with HIV (Brashers et al., 1999; Ezzy, 2000; Pierret, 2001). And a recent study with HIV clinicians found that their own expectations about treatment have been tempered by the growing problems of achieving control of the virus and reducing side-effects (Rosengarten et al., 2004). The ambivalent and fragile qualities of the accounts of living after the advent of treatable HIV suggest threats to ontological security, a perspective that is reminiscent of accounts of lived experience developed prior to the widespread use of effective treatment (Bloom, 1997; Crossley, 1997; Roth & Nelson, 1997). But this thesis argues that these problems for reflexivity are in part manufactured in the science that contributes to HIV treatment. Through Macintyre's argument about HIV medical epistemology and ontological security (1999), I argued that the calculation of the effects of treatment on life expectations undermined the hopes of the interviewees. The ambivalent quality of the post-crisis experience is therefore partly traceable into the science of treatment itself. In this situation, the different ways of constructing the meanings of post-crisis take on significance as methods of resistance. In particular, the different stories about the post-crisis experience present vital methods for resisting the negative aspects of calculability.

The value of uncertainty

The dualistic quality of treatment-related uncertainty is another way this thesis has advanced thinking about post-crisis. Uncertainty is seen as a problem for the imperilled self in general, for example where the individual is seen to: "... ride the juggernaut in hopeful anticipation, [and] never feel entirely secure" (Giddens, 1990: 139). A variation of the figurative 'endangered self' has been applied to the analysis of stigma and the HIV experience (Green & Sobo, 2000). Alternatively the governmentality literature stresses the importance of the disciplinary qualities of uncertainty (Adkins, 2002). In particular, uncertainty has been conceptualised as commodity in neo-liberal governance (O'Malley, 2000). I extended these governmental perspectives to suggest that it is also possible to find value in the forms of treatment uncertainty that enable resistance to its limitations. Uncertainty had positive value because it provided a way of hoping to exceed the calculations and prognostications of medicine. Also, via a sense of reflexivity opened to aesthetics. I argued for the personalised qualities of self-care bent to the accumulation of the positive value of uncertainty. This was a depiction of self-care that departed from the usual psychosocial 'coping' literature common in the area of HIV and chronic illness in general (Siegel & Schrimshaw, 2000). And this conceptualisation of the connection between self-care and uncertainty is a revision of the accepted notion of the 'becoming self' depicted in the governmentality literature that refers to public health (Lupton & Tulloch, 1998). In the situation of imperfect HIV treatment, reflexivity concerns the different values of uncertainty, resisting the negative and conserving and extending the positive.

This thesis also suggested an important alteration in the public and private meanings of HIV and AIDS giving rise to the mutually dependent notions of public complacency and private insecurity. This was an important aspect of the analysis because it suggested the multiple shifts in the meanings of the epidemic with implications both for gay men with HIV and the representation of the post-crisis situation.

The idea of a changed visibility of AIDS has been suggested in policy debate and analysis (Bochow, 2002; Greene & Ward, 2002; Siegel & Lekas, 2002). But only a few have considered how gay men themselves account for the changing meanings of HIV and AIDS after the advent of treatable HIV (Rosengarten et al., 2001; Watney, 2000). Moreover, post-crisis discourse does not typically distinguish between AIDS and HIV (Watney, 2000). But this distinction appears to be a vital one for people with HIV whose lives have been transferred from one ordering of AIDS and HIV to another. In a theoretical discussion of HIV risk and treatment, Flowers has suggested that the post-crisis experience for gay men with HIV is one of privatisation and fragmentation (2001). But this thesis identifies the interdependence of the waning of the apocalyptic character of AIDS and the personalisation and invisibility of HIV and its treatment.

This thesis also raised a related question about moral responsibility in treatment connected with the determinate/indeterminate qualities of some aspects of the treatment experience. In particular, a scientific enterprise of the viro-technical was divided from a personal, subjective domain of ailment. It is important to recognise then that HIV treatment relies on a division of health work, where the work of the patient is hidden from view. Moreover, the interviewees suggested that such work was seen to be best done when it was literally hidden from view, kept out of consultations and out of social

intercourse. HIV medicine, or perhaps medicine in general, by separating off the indeterminacies of well-being, is implicated in a kind of bio-dystopia. Through the sense that ailment is a personal moral responsibility, medicine appears to have evacuated itself from the domain of wellbeing. This is an important perspective on how HIV treatment is able to succeed partially through the concealed self-caring patient. Recent UK policy has articulated the need for 'healthy citizens' and the 'expert patient' (Department of Health, 1999; 2001a). There is scope for elaborating on how these frameworks can be brought into the practice of HIV medicine. But there is also a need to take into these policy frameworks how treatment is divided into biomedical intervention and concealed self-care. The thesis also suggests an irony. Individualisation has the effect of the personalisation of ailment, thereby taking the 'caring' out of health care interventions.

Beyond treatment optimism

Through the idea of reflexive treatment adapted to the situation of gay men with HIV, this thesis critiques the relevance of the notion of treatment optimism and dramatically extends the small literature about treatment and the sexual practice of gay men with HIV. In general, the idea that treatment optimism increases risky sexual behaviour was not relevant to the interview accounts. The analysis did suggest that treatments and sex are linked, but not in the way proposed by the idea of treatment optimism.

Quantitative research about the effects of treatment optimism on risk behaviour has not been able to rule in or out whether treatment optimism causes risk behaviour (Elford et al., 2002; Kelly & Kalichman, 2002; van de Ven et al., 2000). As a result, treatment optimism has therefore become a kind of cul de sac in prevention research. For example, the idea of treatment optimism appears to have become a stock explanation for

observations of risk behaviour among gay men (for example, Wohl et al., 2004). Alternatively, other researchers, sceptical about the link between treatment optimism and risky sex, have stepped away from the area. The idea of treatment optimism has therefore become a risk society problem itself, since public health science, perhaps because of its own epistemological habits, is not able to resolve a problem of explaining the supposed impact of treatment on risk practice.

However, the present research has provided the basis for critiquing treatment optimism in terms of its underlying assumptions and developing a framework of techno-ethics for conceptualising the links between treatment and prevention. Like other qualitative research, the analysis showed that gay men with HIV have not given up safer sex in light of treatment and its effects (Miller et al., 2002; Rosengarten et al., 2001). Further, the interview accounts suggested that gay men with HIV were not optimistic about treatment in the simple sense of 'net' gain for thinking about HIV prevention. Instead, they were ambivalent and cautious about treatment, depicting it as a mixture of benefits and drawbacks. The interviewees were also engaged in sophisticated ways with the uncertain qualities of treatment knowledge and its implications for HIV transmission in sexual practice. Interviewees aimed to resolve the uncertainties and knowledge contests about treatment and risk in sex by adopting paradigmatic or post-paradigmatic positions on HIV prevention. The links between treatment effects and sexual practice is therefore revealed to be an ethical challenge for subjects rather than a solely technical one.

The circulation of both the paradigmatic and post-paradigmatic in risk governance is a distinctive contribution to the existing literature. Although risk relativism has been broached in HIV prevention research, there appears to be no other discussion of this articulation of absolute and relative approaches to risk with the uncertain and

contestable qualities of treatment-related knowledge and its implications for sexual practice (Keogh et al., 1999). It is therefore not possible to accurately speak of a post-crisis epoch distinguished by wholesale displacement of one form of risk management for another. It is also not adequate to suggest that HIV prevention practice is simply 'fractured', 'bespoke' or otherwise individualised because of the advent of treatable HIV (Flowers, 2001; Rosengarten et al., 2001). We can however, speak of the circulation and re-embedding of both paradigmatic and post-paradigmatic forms of HIV prevention method expressed as preference. There was even a suggestion that HIV carers faced something similar in their own deliberations on the implications of treatment for HIV transmission risk in sexual practice. These perspectives underline the risk society qualities of living with HIV treatment. Increased technical know-how does not in and of itself resolve problems of risk. HIV prevention in connection with treatments is a techno-ethical challenge for patients, sexual actors, health care providers and educators.

Preventing HIV and resisting blame

The thesis also suggests how gay men with HIV manage the social expectations of HIV prevention connected with HIV positive serostatus. The idea of altruism on the part of gay men with HIV is the key imperative in HIV prevention research and policy. It implies that gay men with HIV should act to ensure that their sexual partners are not infected with HIV. Via the notion of treatment optimism, some would have it that people with HIV need to negate the positive, curative value of HIV treatment so that they do not start to believe that risk reduction in sexual relations is less necessary. For example, policy makers have suggested that HIV prevention for people with HIV should: "... foster the perception that HIV is still a life-threatening disease despite medical advances in treating it" (Marks et al., 1999: 303). Other analysts have suggested

how late modern forms of risk administration lead into a hierarchy, where the capable are free to act, but the less capable are submitted to more coercive external regulation (Castel, 1991; Lupton, 1999). It seems that HIV prevention in post-crisis is separated according to HIV serostatus. The labour of safer sex is divided so that those with HIV infection are responsible for HIV prevention, practically and morally. This approach is attractive to public health because it provides a method for controlling the epidemic that focuses on the biological basis for disease and identifies individuals for intervention. And through the (discreditable) idea that treatment optimism increases risky sex, HIV prevention with people with HIV focuses on bracketing out the hope embedded in HIV treatment.

However, the interview accounts provide a different, social account of HIV prevention that partly accepts and partly resists the moral injunctions and symbolic violence associated with required altruism and negated hope. Research done prior to, or alongside, the advent of treatable HIV has gone some way in mapping out the different rationalities of sexual risk regulation used by gay men with HIV (Cusick & Rhodes, 1999; Cusick & Rhodes, 2000; Davis, 2002; Keogh et al., 1995; Keogh et al., 1999; Rhodes & Cusick, 2000). But this thesis has taken these perspectives further to suggest the importance of both altruism and cooperation forged in connection with preventing HIV and resisting blame. The interview accounts suggested that altruism worked with the cooperation of sexual partners. Acting altruistically was not simply a way of preventing HIV. It also had the benefit of moderating the blaming that arises when the HIV prevention imperative is attached to HIV positive serostatus. And the interview accounts also suggest an unorthodox connection between the risk-reducing benefits of treatment and sexual practice. For example, letting a partner know one's HIV status prior to sex was a way of helping the partner to choose a risk reduction strategy and

therefore to some extent moderate the blaming of the person with HIV for HIV transmission. And exchanging information about serostatus early in the relationship, helped to moderate the negative effects of possible social rejection. Altruism/cooperation also depended on the HIV serostatus of the sexual partner and the local characteristics of different sexual settings such as the regular partnership or casual encounters. The interview accounts also show that HIV serostatus remains important to prevention. As I have discussed, the suggested treatment-related fragmentation of identity or the emergence of bespoke methods of HIV prevention did not have much support (Flowers, 2001; Rosengarten et al., 2001). It is suggested that the importance of HIV serostatus endures because required altruism speaks to categorical sero-identities. In addition, the altruistic imperative is embedded in the cultural organisation of the risk relationship, that is, 'at risk' and 'a risk' (Douglas, 1992). Further, HIV treatment and its risk reducing benefits appear to be valued because they reduce anxiety about transmitting the virus and therefore assist with the project of mitigating blame. In this way, treatment has value for the promotion of security in sexual relations, much as treatment is used to promote life and therefore has implications for ontological security.

This cultural analysis of treating and preventing HIV therefore exposes the moral quality of required altruism. It also connects with critiques of HIV risk reflexivity to do with structure and agency (Adkins, 2002; Race, 2001). Gay men with HIV are free to engage the benefits of HIV treatment but only in certain ways. A related critique of the thesis therefore concerns a more general perspective on social action. Beck has entertained the idea of "... altruistic individualism" in a small way in and around the construction of sexual intimacy in late modernity (Beck & Beck-Gernsheim, 2002: 212). But he also describes this as a social form that requires invention because: "No one has the answer as to how this will work" (Beck & Beck-Gernsheim, 2002: 212).

Lash and Adkins have each advocated for reflexive forms of ‘we’ or community to overcome the atomising of more rationalistic conceptualisations of reflexivity (Adkins, 2002; Lash, 1994). This thesis suggests how gay men with HIV take up the mission of working out how to construct sexual relationships in light of their obligations and desires, a mission that resonates with the post-crisis contest about acceptable forms of risk reflexivity and it seems with the more general problem of self and community in late modern society.

Knowledge claims in epidemic time

In chapter four, I addressed concerns about knowledge claims in connection with sampling and analytical bias. But there is also an important provision related to time and the changing capacities of HIV treatment and prevention. Some time has elapsed since this research was done. New treatment combinations have been introduced. People have had longer to use effective treatment and clinical knowledge has accumulated. So a question is possible about whether the post-crisis thesis developed here is particular to a certain moment. But as I have also suggested, this thesis advances knowledge about treating and preventing HIV, principally through attention to the accounts of gay men with HIV themselves. The notion of reflexive treatment and its elaboration in connection with the sexual practice of gay men with HIV also provides a conceptual framework that is sensitive to the social construction of change. This thesis supports the dynamic vision of the HIV epidemic suggested by Watney, where medical watershed assumes too much (2000). Dynamism also means that other accounts will revise and displace this one. The HIV epidemic cannot be addressed solely in the sedimentation of certain knowledge, precisely because the epidemic is dynamic and open to contest over the terms of its meaning and governance. The various limitations of traditional forms of knowledge-making about living with risky HIV medicine identified in this analysis

suggest the need for an elaboration of an 'epistemology of uncertainty'. In this view, the practice of iterative dialogue about living with HIV treatment seems in keeping with the conditions of proliferating uncertainty and contest and therefore the challenge of techno-ethics in sexual practice.

Summary

Post-crisis concerns about the connections between treatment and the sexual practice of gay men with HIV can be viewed as part of a more general engagement with changes in treating HIV. Put another way, the advent of treatable HIV is one aspect of the wide ranging contest about acceptable modes of risk reflexivity that has characterised the epidemic. HIV treatment, like any science-based social intervention, brings to the HIV epidemic another layering of manufactured uncertainty, adding technical and ethical complexities to questions of security. And in this situation, the risk management potentials of HIV treatment are in part governed through the idea of unruly sexual conduct on the part of the notional gay man with HIV. As I have argued, gay men with HIV are themselves engaged with managing the precarious and provisional freedoms of this domain of treatment technology and sexual relations. But there is a remaining question about what sort of HIV medicine comes into being in the coming years and the sorts of lives that are possible in these circumstances. Some aspects of post-crisis discourse auger for the intensification of a moral order figured around the medical characteristics of the individual. This kind of possibility alone underscores the need for a continued knowledge-making practice of engaged and critical dialogue with people with HIV about living with HIV treatment.

APPENDIX ONE: SOCIAL AND TREATMENT CHARACTERISTICS OF THE
INTERVIEW SAMPLES

Table One: First sample social descriptors and treatment experience (n=25)

Age	The interviewees were aged 25 to 55, with an average age of 36 years.
Ethnicity	Twenty-three interviewees were British, Anglo-Australian, or white European.
Education	Thirteen interviewees had a university or college education.
Employment	Fourteen interviewees were employed or studying full-time.
Regular Partner	Eight interviewees were in a regular partnership at the time of the first interview (the duration of six of these relationships was 18 months or less). All these regular partners were reported to be HIV negative.
Year of HIV diagnosis	Three interviewees were diagnosed in the mid 1980s; sixteen interviewees between 1990 and the end of 1996; six interviewees from the beginning of 1997. The small number of interviewees diagnosed with HIV prior to 1990 reflected the greater mortality of people with HIV diagnosed with AIDS in the 1980s.
HAART*	Sixteen interviewees were currently using treatment.
Duration of HAART	Five interviewees had been on treatment for 12 months or less; nine interviewees had been on treatment for between 12 and up to 24 months; two interviewees had been on treatment for more than 24 months.
Reported viral load	Fifteen interviewees reported that they had an undetectable viral load. Ten interviewees reported that they had a detectable viral load, were unsure or did not report it.

* HAART = Highly active antiretroviral therapy

Table Two. Second sample social descriptors and treatment experience (n=11)

Age	Ages ranged from 27 to 55 years with an average of 38 years.
Regular partners	Four of the interviewees were currently in a regular partnership (all with HIV negative partners)
Treatment experience	Three of the interviewees were not taking treatment

APPENDIX TWO: ‘ASSUME NOTHING’ ADVERTISEMENT

PAGE

NUMBERING

AS ORIGINAL

It's your shout

no one mentioned condoms.
assumed he must have HIV too."
assumed he was HIV negative like me."

Assume Nothing

**APPENDIX THREE: ETHICAL APPROVAL LETTER, INFORMATION SHEET
AND CONSENT FORM**



CAMDEN & ISLINGTON

Community Health Services NHS Trust

Your Partner for Health

LOCAL RESEARCH ETHICS COMMITTEE

Research Office, 3rd Floor, West Wing, St. Pancras Hospital,
London. NW1 0PE

tel: 020 7530 3376 fax: 020 7530 3235

e-mail: research.office@dial.pipex.com

Chair: *Stephanie Ellis* Administrator: *Michael Peat*

Monday, 17 July 2000

Mr Mark Davis
Department of Sexually Transmitted Diseases
Mortimer Market Centre
off Capper Street
LONDON WC1E 6AU

Dear Mr Mark Davis

Application No: 00/55 (please quote in all further correspondence)

Title: A qualitative study about sex and risk with HIV positive gay men attending an outpatient centre in London

This project has been considered by the Ethics Committee, and I am pleased to inform you that they were able to give their approval for it to proceed. However, the committee would like the investigator to consider re-defining the purpose of the study as stated in the patient information sheet and consent form. It was agreed that there should be a re-emphasis of the wider benefits of taking part in the study.

Please would you write and inform **Angela Williams** of the start date of your project, at the above address.

Please note that the following conditions of approval apply:

- ♦ It is the responsibility of the investigators to ensure that all associated staff including nursing staff are informed of research projects and are told that they have the approval of the Ethics Committee.
- ♦ If data are to be stored on a computer in such a way as to make it possible to identify individuals then the project must be registered under the Data Protection Act 1984. Please consult your department data protection officer for advice.
- ♦ The Committee must receive immediate notification of any adverse or unforeseen circumstances arising out of the project.

- ♦ The Committee must receive notification: a) when the study is complete; b) if it fails to start or is abandoned; c) if the investigator/s change and d) if any amendments to the study are made.
- ♦ The Committee will request details of the progress of the research project periodically (i.e. annually), and require a copy of the report on completion of the project.

Please forward any additional information/amendments regarding your study to Michael Peat or myself at the above address. If you have any queries, please do not hesitate to contact Michael Peat at the Research office.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Stephanie Ellis'.

Stephanie Ellis
Committee Chair

CONFIDENTIAL

Research Information Sheet

A qualitative study about sex and risk with HIV positive gay men attending an outpatient centre in London

You are invited to participate in a study about the social aspects of risk, sex and living with HIV. This study is part of my PhD in Policy Studies at the Institute of Education, University of London.

What is the purpose:

Recently you were interviewed as part of the SHARP project. For my doctoral studies I would like to be able to use your interview. I would also like to invite you to participate in a follow-up interview.

The Study:

There are two aspects of this study.

1. Your SHARP interview.

This will be used along with interviews of HIV prevention workers, HIV and AIDS policies and health promotion materials, to look at issues such as:

- How gay men with HIV talk about sex, risk and HIV
- The ways in which policy and health promotion approach sex, risk and HIV for gay men living with HIV
- Impact of HIV treatment advances

2. The follow-up interview.

The follow-up interview will be similar to that for SHARP, but will explore how drug treatment and sexual practice has been for you since the original interview. The second interview will be conducted by me, tape recorded and transcribed word for word.

How long will the study last?

Your follow-up interview will be for 1 to 1.5 hours and will be conducted in the next 12-18 months. The overall study is designed to run over the next 4 years, part-time.

What are the risks?

Very few! You may find that the interview brings up emotional concerns for you. At this point we can arrange an appointment with a health adviser.

Privacy and confidentiality

All interview material is confidential. The information is not linked with your care and treatment at Mortimer Market in any respect. All data derived from your interview(s) is made anonymous in any report or presentation. As with SHARP, you are welcome to make a time to see a health adviser to discuss any aspect of your involvement in the research. **All proposals for research using human subjects are reviewed by an ethics committee before they can proceed. This proposal was reviewed by Camden and Islington Community Health Services NHS Trust, Local Research Ethics Committee**

PTO

What does the study involve

You can choose to be involved in two ways:

- 1 Consent to use of your SHARP interview transcript for my research
- 2 Consent to a follow-up interview

There are no other requirements for the study.

What will you have to do

On the sheet provided indicate your level of involvement and provide contact details if appropriate. **You do not have to take part in this study if you do not want to. If you decide to take part you may withdraw at any time without giving a reason. Your decision to take part or not will not affect your care and management in any way.**

Feedback

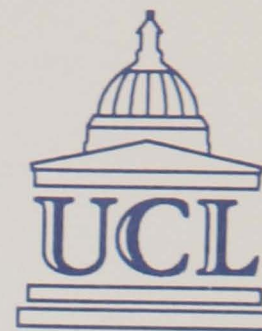
The study is a post-graduate research project and is not directly linked to policy or care and treatment services. However, as part of the requirements for the PhD award, I will prepare academic publications and reports, as well as the final thesis document. You may request a copy of any of these papers and/or discuss them with me.

For further information contact Mark Davis on 020 73879300 x 8243 or my supervisor Dr Eva Gamarnikow, Institute of Education, University of London 020 7612 6000.

Thank you for your attention

Mark Davis

17 March 2000



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Research Consent Form

A qualitative study about sex and risk with HIV positive gay men
attending an outpatient centre in London

Researcher: Mark Davis, PhD Candidate, Policy Studies, Institute of Education,
University of London
Supervisor: Dr Eva Gamarnikov, Lecturer, Policy Studies, Institute of Education,
University of London

Please circle and complete the following where relevant:

I have read the information sheet about this research, dated 17 March 2000	Yes	No
I have had the opportunity to ask questions and discuss this research	Yes	No
I have received satisfactory answers to all my questions	Yes	No
I have received sufficient information about this study	Yes	No
I agree to take part in this study	Yes	No
I consent for my SHARP interview transcript to be made available to Mark Davis for PhD research	Yes	No
I wish to participate in a follow-up interview	Yes	No
I consent to provide contact details so that Mark Davis can contact me	Yes	No
I understand that I am free to withdraw from this study:		
• At any time		
• Without giving a reason for withdrawing		
• Without affecting my future medical care	Yes	No

Name of interviewee
(block letters)

Contact details (if relevant)

Signed (interviewee)

Date

Signature if Investigator

Date

APPENDIX FOUR: TWO EXAMPLES OF THEMATIC ANALYSIS

Introduction

This appendix promotes transparency by providing additional detail regarding the data analysis. It uses two examples to show how themes were established and developed. Importantly, the appendix aims to show how thematic development and writing were interdependent. It also addresses the question of rigor, by describing the approaches and techniques used in the analysis to strengthen the analysis.

The appendix focuses on two themes: HIV transmission risk and viral load; and self-care connected with treatment uncertainties. Each example traces out the analysis procedure, from initial forms of data treatment to written presentation. They demonstrate the contribution of several approaches used in the analysis, in particular: iteration; segmenting; comparing and contrasting; gradual focusing. The examples emphasise two important techniques: searching for convergence in the data as a way of establishing themes; and considering ‘deviant’ or contrasting cases as a way of assessing and re-defining themes. The second example also draws attention to how case studies were used in thematic analysis.

Developing and writing about themes of analysis

Figure One below is a generalised portrayal of the important aspects of data analysis. It shows the two interdependent steps in the procedure: establishing a thematic framework; and writing. The figure shows iteration or reflective cycling between thematic analysis and writing. It also notes the key aspects of each main step.

Establishing a thematic framework

In this stage, data is ‘chunked’ into manageable and pertinent segments. These data segments were compared and contrasted by reading and reflecting on them. Gradual focusing of themes was achieved by searching for convergence of interview extracts on a particular theme and or identifying and addressing ‘deviant’ or contrasting cases. Gradual focusing of the meaning of individual themes also addressed how they related to other themes, giving rise to a framework. Computer software (NVIVO) was used to facilitate data management.

Writing as a form of analysis

This part of analysis comprised various forms of presentation of the interpretations of themes. For example, explanatory memoranda were used to reflect on each theme and assisted with gradual focusing. These memoranda focused on convergence and on ‘deviant’ cases. Reflective writing often led into a re-organisation of the themes. A technical report was prepared to summarise the thematic framework based on the first 25 interviews. This technical report was the basis for the preparation of a published article (Davis et al., 2002). It also provided part of the basis for the decision to conduct re-interviews. Individual case studies were written about each of the eleven re-interviews. These case studies were drawn into a thematic analysis of the re-interviews.

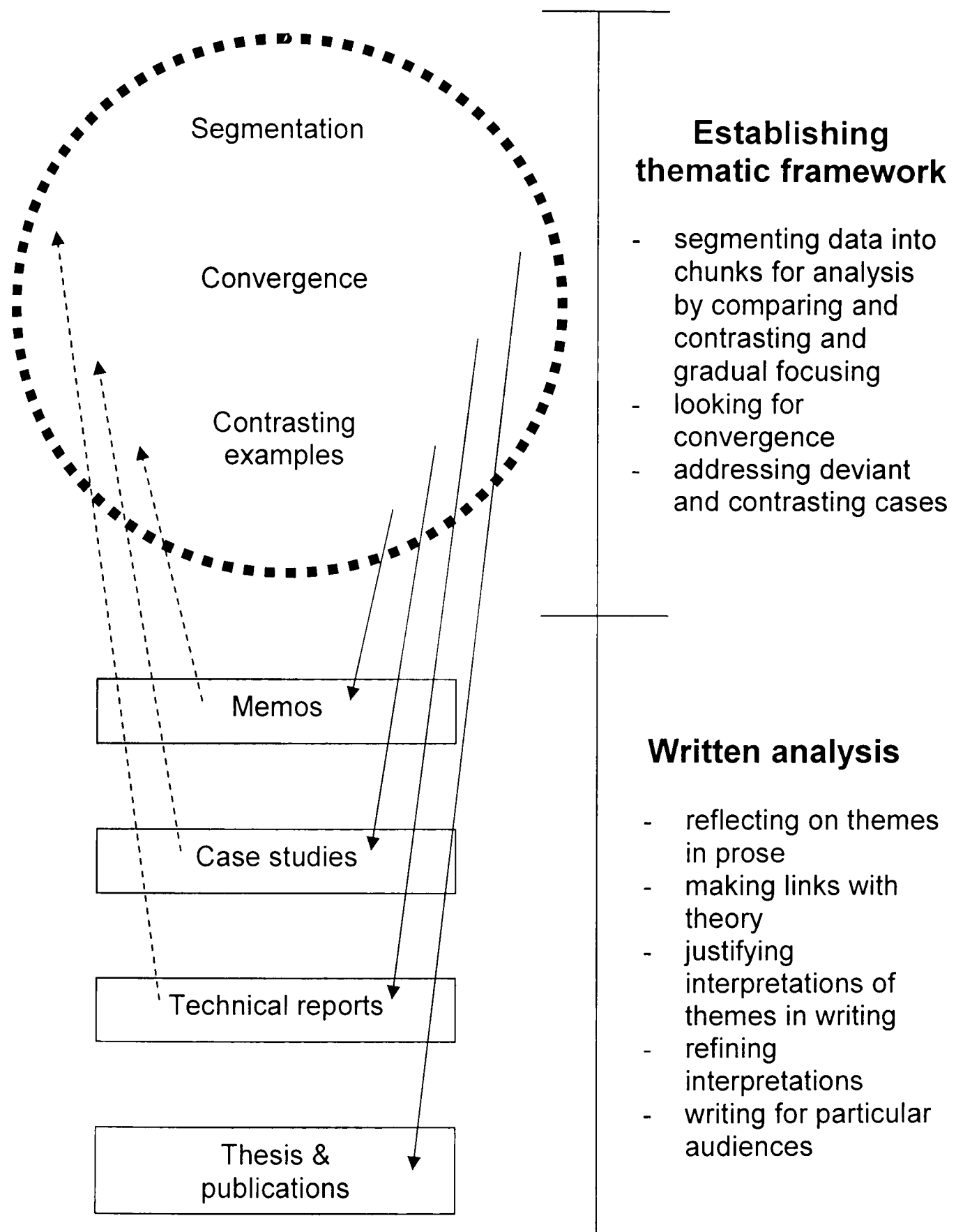


Figure One: Developing and writing about themes of the analysis

Example One: ‘Techno-ethics’ in discourse about viral load

This theme concerns interview accounts about viral load and risk of HIV transmission. Viral load is jargon for the blood tests that measure an analogue of the amount of virus in the blood. Low viral load, especially ‘undetectable’, is a desired treatment outcome. Viral load also has implications for HIV transmission in sexual practice. There is much debate, but it may be that low viral load reduces the risk of HIV transmission.

Collecting segments of transcripts around a theme

The following table contains examples of how interview transcripts were segmented and categorised in the theme of ‘viral load’. There were 17 extracts in total. Some extracts presented are quite large and include questions and extended discussion. This approach to segmentation maintains some of the context of the interview discussion, but allows for gradual focusing and clarification of the themes. This process of segmentation also provides the basis for searching for convergence and identifying ‘deviant’ cases.

Table One: Interview extracts categorised as ‘viral load’ with written justification.

Extract from interview	Rationale for inclusion at ‘viral load’
Document 'P2N01Rodney' MD: So for you, you do safe sex because of the other things as well? INT1: Oh yes. Yes. And also if I, even if I have unsafe sex with somebody who is HIV chances are I could make my position worse. MD: How? INT1: The person who, the HIV person I’m with might have a different strain of the virus which he could transmit to me, or vice versa. I mean I don’t know, to be honest, but touch wood my strain seems to be quite weak. I mean that’s just my guess because I’ve had no symptoms for so long. MD: So you’re quite well at the moment. INT1: At the moment, yes. I’ve done nothing to deserve that, terrible diet and I drink too much. MD: I see. INT1: No, it’s true. MD: So, do you have viral load tests? INT1: Hmm, yes.	This extract involves discussion of personal viral load testing and advice from the HIV doctor about the health implications of low viral load. It also includes discussion of the HIV prevention implications of low viral load.

<p>MD: And what is your, do you know what it is?</p> <p>INT1: I can't remember the number, but – is it 300, 400? It's quite</p> <p>MD: And your CD4 count?</p> <p>INT1: (???) I mean I was speaking to my doctor yesterday who seemed to be quite happy with me.</p> <p>MD: So, knowing about that your virus may be not a very strong one, so it's kind of weak.</p> <p>INT1: Well, that's my guess. But it's still there, you know.</p> <p>MD: Does that change your ideas about how infectious you might be to another man for HIV?</p> <p>INT1: No, no it doesn't. To be honest, the business about my virus being weak is something which I've never actually said aloud before to anyone. It's been in the back there and maybe this conversation's brought it up, but a virus is a virus no matter how potent it is, you know.</p> <p>MD: So, it's not a matter of degree, it's there or it's not?</p> <p>INT1: Yes, definitely.</p> <p>MD: So, how much do you know about the new anti-retrovirals? What sort of ...</p> <p>INT1: Very little. I did have a conversation about them, but I think it was December.</p> <p>MD: Yes. And how did that come about?</p> <p>INT1: I asked and the lady upstairs, (???) showed me all the books. There's various leaflets and things upstairs, and I read about that in the books.</p>	
<p>Document 'P2N03Michael'</p> <p>MD: Okay. Let's jump to HIV and viral load, and you said like when you're with your current partner your mind is sort of thinking about unsafe sex, one of the things is like the viral load's undetectable therefore the risk is reduced.</p> <p>INT3: Hmm.</p> <p>MD: So viral load and infectivity are linked for you? Is that, at some level it seems like they are.</p> <p>INT3: At some level, yes it is. Logically I know that just because when they take a small blood sample they can't find it in that blood sample doesn't mean that it's not going to be passed on to him. But the fact is that, you know, there's that part of me that wants to believe that I'm HIV negative now. And that's what it comes down to. When, if they can't find any HIV in a blood sample then I don't have it. And it's a kind of, a form of denial I suppose in some ways, it's like I'm cured, you know, it's – I now have that manageable, controllable illness like diabetes that they've all been talking about for these last few years, you know, it's just something that I just have to keep taking the tablets and I'll be fine. And I know intellectually that that really isn't the case yet. It may be, but as I'm sitting here now it really isn't, and I'm still infectious to a – I would presume to a lesser extent than I was before, but still nonetheless presumably infectious. That's the difficult bit, the difficulty is there's not any research that's been done in this area really that says, you know, oh well – it's like, you know, the risks of oral sex, the fact that do people get infected through oral sex. It's like okay, and now the thing is well do people get infected if your viral load is undetectable. Who knows. But it's not worth taking the risk that I may infect him just because I think 'well it's not likely is it'. But it's difficult when that man wants to tell me that actually it is okay. It's that balancing up the emotional response with the intellectual response. And I always manage to, as I say I always manage to vocalise the intellectual response.</p>	<p>In this extract the interviewee makes links between considerations of viral load and sex with his regular HIV negative partner. It discusses both the technical and the ethical in considerations of treatment effects and risky sex.</p>
<p>Document 'P2N08Tony'</p> <p>THE SCREWING AROUND AND DRUG RESISTANCE, WHAT'S THAT ABOUT?</p> <p>Well it's what they say in the papers isn't it? That if you... there has been a lot in the papers about what is it? HIV people or people with AIDS say like bare backing with each other 'cause they say, hey well I've got it anyway what the</p>	<p>This extract reveals yet another engagement with the idea of low viral load and infectiousness. In particular, the extract suggests that technical</p>

<p>hell? But then the argument or supposedly the argument is you pick up resistance to the combination the other person's using and therefore you limit your future options and blah-blah-blah so it's not such a good idea.</p> <p>SO IT'S NOT SO MUCH SCREWING IT'S SCREWING WITHOUT CONDOMS?</p> <p>Yeah I suppose so yeah. Unsafe sex yeah.</p> <p>[Later]</p> <p>The stupid ones. I just think you're taking a risk. And yeah there may be more risk to be being passive but you're taking a risk and there's a number of factors and you know... and that's about it.</p> <p>WHAT ABOUT SEX? BE GOOD TO LOOK AT LIKE... ONE OF THE EFFECTS OF THE ANTI HIV DRUGS IS LIKE REDUCING VIRAL LOAD AND UNDETECTABILITY OR NEGLIGIBLE VIRAL LOAD. SO HOW DOES THAT RELATE TO RISK?</p> <p>Well I've heard that one before as well and to me it's another load of codswallop. Complete codswallop. I mean that's sort of delusion isn't it? You're saying the viral load is so low that even if body fluid passes you know there's so little of this whatever HIV in it that so what? Even if there's a tiny bit in it maybe it takes a bit longer to grow... again it's complete self delusion. I've heard that one so many times as well that my viral load is low therefore my, your chances of picking it up from me are negligible I thought was complete bollocks. It's self delusion, it's just another way of excusing having unsafe sex as well. I don't believe it... I mean I practise unsafe sex but I've never deluded myself with any of these arguments whatsoever.</p> <p>DIDN'T YOU SAY THAT THERE WAS A GUY WHO'D SAID IT? LIKE A POSITIVE GUY.</p> <p>Yeah he said... well that would have been a few years ago and I suppose at the time it seemed quite an attractive argument. I just sort of took it. I mean he probably believed it 'cause that would have been three years ago, that was quite a long time ago. So things have moved on and I don't really... I think this viral load thing and risk of transmission I don't know if there's any relationship and as I've said I just think it's a bit of a red herring really. 'Cause they're still saying it is present but we're not measuring it, so...</p> <p>SO IF OTHER PEOPLE ARE KIND OF RATIONALISING UNSAFE SEX THEN YOU WEREN'T?</p> <p>Unsafe sex?</p> <p>YEAH, SORRY, UNSAFE SEX.</p> <p>Well three years ago I might have been, I don't know, I mean things change obviously over the years. I mean certainly in the last eighteen months I take the view that any sort of unsafe sex is risky and all of these sort of cop outs, I've got a low viral load or I'm the active or I'm the passive one, I didn't come inside you. You know, all these sort of standard cop outs I just think they're just...</p> <p>SO WHAT'S CHANGED THOUGH?</p> <p>Well I suppose I've, well I've obviously read an awful lot and I tend to believe more what I read. You know, unless proven otherwise then unsafe sex is unsafe sex. There's no sort of qualifying it with these other possibilities. You might as well say the guy looks healthy therefore not very high risk or the guy looks like a beanpole then he is high risk, it's that sort of rather crude way of looking at things.</p> <p>AND WHAT ABOUT DRUG RESISTANT VIRUS? WE TALKED A BIT ABOUT THAT ALREADY.</p> <p>In the back of my mind that is something which I'd rather it... I'm worried obviously. If the present combination were to fail then obviously I don't want to try another combination which I've already tried through the back door a few years previous and developed resistance to. So again you know it's in my own interest to have safe sex with someone else let's say who's positive and taking drugs.</p>	<p>knowledge about relative risk is rejected on the basis of a pre-existing approach to safer sex.</p>
Document 'P2N09Colin'	This extract refers to

<p>YOU SAID BEFORE THAT YOU KNEW YOUR SEMEN DIDN'T...</p> <p>Yeah, well I did a survey earlier this year...</p> <p>WHO WITH?</p> <p>With...</p> <p>CLINIC DOCTOR?</p> <p>Yeah. And I was part of the control group because I didn't have gonorrhoea (laughs) and he came back and said we can't find any virus in your semen or sperm. I was quite shocked actually by that but I have read things in the papers and magazines over the years of being just left in the spleen and the tonsils. So why not just have one's spleen and tonsils out and be done with it!</p> <p>[Later]</p> <p>JUST TO SORT OF EXTENDING THIS KIND OF DISCUSSION ABOUT RISK, LOOKING AT YOU KNOW UNDETECTABLE VIRUS, YOU TALKED ABOUT SEMEN AS WELL. WHAT, HOW DO YOU SEE UNDETECTABLE IN TERMS OF IT?</p> <p>I see myself as about infective as a squashed tomato, that's how I see myself.</p> <p>SO YOU DON'T SEE THAT YOU COULD PASS ON HIV?</p> <p>I didn't say it was impossible but I think it's very, very slim the chance. That's what I would like to think anyway.</p> <p>BECAUSE OF UNDETECTABLE VIRAL LOAD AND THE COMBINATION THERAPY...</p> <p>Undetectable viral load and no virus in my semen, sperm. Um...</p>	<p>participation in a research study about viral load in semen and related assessment of risk of transmission.</p>
<p>Document 'P3N16Peter'</p> <p>M: The final thing around risk stuff is, like, um, undetectable viral load, what you think that means in terms of HIV?</p> <p>R: A thing you just can't see it. I think it lurks there, I don't think it's gone away, I think, you know, wack! If I come off the drugs it's going to shoot back up, and I think...I think 'til we know more about what is going on, and I think it's still very early stages, or a vaccinate cure, you know, it's a word. It's "undetectable", it's a word, you can abuse things, and I don't think we want to go down that alley-way.</p> <p>M: Do you think a positive man with undetectable viral load is less infectious than ??</p> <p>R: No, I don't actually. No.</p> <p>M: 'Cos some people are saying that it is like you are less infectious...</p> <p>R: Well, that's up to them, but it's not how I think, I don't...but the thing is, at the end of the day, it's not just HIV, I don't want to get syphilis, I don't want to get gonorrhoea, I don't want to get whatever else is there, I don't want all that.</p>	<p>This extract reflects discussion of viral load and infectiousness. It also introduces the notion that risk positions are individualised.</p>
<p>Document 'P2N05David'</p> <p>I'M JUST WONDERING IF UM... YOU KNOW, THE NEW ANTI RETROVIRAL DRUGS HAS KIND OF HAD AN IMPACT HERE AROUND PERCEPTIONS ABOUT HOW INFECTIOUS... YOU SAID UNDETECTABLE...</p> <p>Yes if you're an undetectable level what does that mean? How undetectable is undetectable? How little HIV do you need in order to infect somebody else?</p> <p>Keep having to say don't know at the moment. Your undetectable is only as good as your last blood test, you know, and that could change at any time. Um... for all I know it is may change day by day, you know, it just happens to be on the days when you're tested you're undetectable. Who knows, it might be slightly detectable at some stage and then it goes down again. No one gets results of that kind on a day to day, hour by hour basis do they I don't think any more.</p> <p>BUT IS IT AN ISSUE FOR YOU? IS THAT A FACTOR IN YOUR CALCULATIONS ABOUT..?</p>	<p>In this extract the interview reflects on the inherent uncertainty of viral load measures</p>

<p>It's a great unknown isn't it? God... um... (pause) Sometimes it does occur particularly in sex. But look at it this way, it's part of a pattern. During sex I often had and I allow myself to have fantasies of being in a certain way. I mean I fantasised that I had full blown AIDS in the middle of the sex and the sexual act was like a way of you know in a cathartic sense experiencing that degree of illness and then triumphing over it. You know allowing yourself to feel totally ill and sick and dying and even dead, you know, in order to then purge yourself of if you like the desire to feel like that. Because I have to be honest with myself that I have deliberately put myself in the situation where my health is impaired, is endangered and then impaired. And I have to be, I have to accept that that is what I have done through my own choice and a way of doing that is through the kind of natural fantasies of sex, which kind of like warps what your question was maybe driving at but from my person point of view I think that's the way my mind works.</p>	
<p>Document 'P3N14Vincent'</p> <p>I: A little while back you were talking about being undetectable, the viral load.</p> <p>R: Yes.</p> <p>I: And seeing that as lowering the risk of transmission.</p> <p>R: Yes, that's only just to make me feel better about what I'm doing [laughter]. I mean I believe it, but it's like, you know, it's, in the scheme of things I don't really buy that. I mean I believe it to be true.</p> <p>I: Well, I think it is now –</p> <p>R: No, I think, I think by having, I think by having my viral load as low as it is I am not as infectious, but I'm still infectious. So it's just, it is, you know, yes, I'm putting somebody at less risk, but that's kind of</p> <p>I: But it's still there.</p> <p>R: It's still there, and that's, you know, you either say, you know, you're HIV positive or you're not HIV positive. And yes, I can... Obviously the viral load makes a difference, but in the scheme of things, you still have to make that decision about whether or not you have, I mean I am HIV positive, then I have to decide whether I have unprotected sex with somebody or not, and I'm very, I... You know, by saying my viral load is low, it's kind of, it's like on the second level of reasoning. You know, you've got to justify the first one, and then, you know, then the second one. I mean that, I can see, this has just come into my mind off the top of my head, but you know, say I met somebody, I told him that I was HIV positive and they were HIV negative and we started having a relationship, and they understood about what viral load was and everything, they might decide at some point to have some form of unprotected sex, based on the – I mean that, I can conceive of that, you know. It might just, it mightn't be aggressive but it could be, you know, like it could be a sense where, you know, if, if you were somebody who would insert their penis in the anus then, you know, you could conceive, you know, conceivably very well, you know. You could chose to get to that point of trust with somebody to, you know...</p> <p>I: Instead of sort of?</p> <p>R: Yes, knowing that, you know, you're in a loving relationship, you're having, you know, and, and it's an informed choice that you could both, conceivably you could both make, you know.</p> <p>I: But both partners would have the same knowledge?</p> <p>R: Exactly, yes. No, I mean I, you know, I don't know what I'm going to do, I don't know what I'm going to do.</p>	<p>In this extract the interviewee discusses low viral load and infectiousness. It maps out how low viral load may be connected with some forms of unprotected sex. 'Informed choice' emerges as a theme of considering the technical and the ethical in matters of sex and treatment.</p>
<p>Document 'P2N10Kevin '</p> <p>WHAT ABOUT, YOU KNOW YOUR... AT THE MOMENT YOUR VIRAL LOAD'S UNDETECTABLE EVEN BY THE MOST STRINGENT MEASURES SO IS THAT A FACTOR IN THE RISK?</p> <p>No. Um... From again what I understand from speaking to my doctor and from</p>	<p>This interviewee refers to advice from his doctor and literature in relation to HIV infectiousness and viral load.</p>

<p>my own reading around the subject it seems that a low viral load in your blood system is no guarantee that there's no HIV in your semen or that there's a similarly low reading of HIV there. And my understanding also is that even if the drugs penetrate your blood stream so as to suppress HIV there that it can be in all sorts of other places, like your brain and lymphatic system. So I don't assume that 'cause I've got a low viral load that I can screw people without risking them I don't think.</p>	
<p>Document 'P2N11Robert'</p> <p>WHAT ABOUT UM... IN RELATION TO KIND OF UNDETECTABLE VIRAL LOAD, DO YOU THINK THAT MAKES A DIFFERENCE FOR INFECTION?</p> <p>No, no, no. The fact it doesn't show up on a test doesn't mean... OK your viral load might be one but it's still there. I mean if we find a cure for it and you can sort of obliterate it completely then you know maybe, then maybe it's OK I don't know. But at the moment all it means is that the test isn't sensitive enough to show the HIV that's my belief.</p> <p>SOME PEOPLE SAY, SOME PEOPLE ARE STARTING TO THINK IT REDUCES RISK.</p> <p>Actually I was reading the leaflet with my drugs the other day which I hadn't read before because I got some leaflets from here and you know to me it was so obvious. But it said Stavudine is not a cure for HIV, you know, you should still have protected sex. I don't know, I can't see it would reduce the risks surely. 'Cause if you've got... your viral load is how many HIV cells you have in each milligram of blood isn't it, or something like that. And surely if one little drop of your blood or sperm mixes with someone else's blood then you've got that one HIV cell that can infect them.</p> <p>COULD THE CHANCES BE REDUCED?</p> <p>I don't see that, I can't see that. You know, unless we can find a treatment that sort of obliterates it completely.</p> <p>WHAT ABOUT OTHER PEOPLE YOU KNOW? WHAT DO THEY SAY ABOUT VIRAL LOAD AND STUFF?</p> <p>Um... (pause) I don't think I've really discussed it to be honest. I mean the only thing is I said to... (pause) If I discuss it with other people who are positive they tend to, we tend to talk about viral loads rather than CD4 count because they reckon that the um... severity of the problem is measured by your viral load rather than CD4 count. But that's all I can say about that really.</p>	<p>This extract also refers to HIV prevention and viral load. The interviewee seems to rely on a present, categorical HIV. Safe sex remains necessary until treatment 'obliterates' HIV.</p>
<p>Document 'P3N15Timothy'</p> <p>M: What do you think about undetectable viral load and HIV transmission?</p> <p>P: Oh, I'm sure it's still the same, even though it's undetectable, it can be given in other parts of the body. It might be undetectable in your blood, but it's still there, it's not like it's gone completely. As they say, it can be hiding in other glands, and stuff in your body. I don't think it makes any difference whether it's undetectable or not. You've still got HIV, you're still positive, and you're still carrying the virus, doesn't mean to say they've killed it off.</p> <p>M: But do you think you're less infectious?</p> <p>P: I don't really know, I wouldn't have thought so, I mean, it's just common sense. I wouldn't think I was less infectious, no.</p> <p>M: Some guys do think they are.</p> <p>P: No, I just feel that the drugs are keeping it under control, it's there, but it's not gone, it's still there, and it's still infectious, it's a virus.</p> <p>M: Your friends, who are positive. Do you talk about these kind of things with them, like sex, and viral loads?</p> <p>P: We talk about viral loads, I don't think I talk so much about sex, because I mean...I've got a really close friend, 'cos I go to Body Positive, and I'm doing a computer course with my best friend, and we chat about how we're feeling, and we'll talk about things, but not, we don't hark on it all the time, we</p>	<p>This extract resembles other constructions of low viral load and infectiousness. 'You've' still got HIV' foregrounds a categorical sense of self with HIV.</p>

<p>don't want to.</p> <p>M: So you don't have an impression about what they think about undetectable viral loads, and HIV transmission?</p> <p>P: No, because I think that the close friends that I know that are HIV positive...are quite sensible guys. I mean, some of them, have been positive for fourteen, fifteen years, when it first started, so...it's not...I mean, it was nice that when I was diagnosed positive, I was able to ring them up and talk to them, because the day I was diagnosed I was in shock. But I just had to ring one of them up, and we sat talking for ages, and a crowd of friends came round the next day to talk to me, you know. Everybody was very supportive, I wasn't shunned by anybody.</p>	
<p>Document 'Stephen, re-interview'</p> <p>Yes, is terribly dangerous and not - a very unsuitable option. So even for two people who are positive, you know, farting around with condoms and without taking a few precautions here and there, um, is really, is not as dangerous but, you know, it has its dangers. Which may not be immediately apparent. I mean there's no kind of, you know, you're either infected or you're not, there is a huge degree of, you know, you can be very badly infected, you can be a bit infected, and, you know, if you alter that ratio I mean the drugs alter it so that you're only a bit infected and then people go out and put themselves in situations where they might get more infected. It seems odd.</p> <p>MD I WAS JUST, WHEN I INTERVIEWED YOU BEFORE I DIDN'T QUITE GET THE MESSAGE AS STRONGLY ABOUT HOW YOUR CD4 COUNT WAS SO LOW FOR SUCH A PERIOD OF TIME, IS THAT PARTLY WHY REINFECTION IS SUCH A BIG ISSUE, BECAUSE ...</p> <p>No. No, no, no. I mean my CD4 count being low is a fact. I mean unless every single reading has been wrong. I mean I'm sure there is the odd rogue reading, but, you know, in a history as long as mine statistically it's, let's say, accurate in as much as anything in this world is accurate. You know, a standard deviation of about 5%, we can live with that. That's just a fact, I mean that just proves to me that whatever I do to fight what should be going on is working. Now whether it works for anyone else I don't know, but if it works for me and somebody else hasn't thought of it and they find out about what I think I'd do to solve the problem and it helps them, well, that's good.</p>	<p>This extract comes from a re-interview, ostensibly in a discussion of reinfection risk. It is categorised at viral load because it refers to 'badly infected' and 'a bit infected'. These constructions seem to rely on a notion of variable viral load and therefore admit relative risk. It shows that discourse about reinfection and infectiousness are connected.</p>
<p>William re-interview</p> <p>MD: But um how um your viral load what is that like?</p> <p>I: Undetectable</p> <p>MD: So how does that make you think about oral sex?</p> <p>I: It doesn't make me think that I'm any less infectious</p> <p>MD: Really</p> <p>I: Hum I still think I'm infectious as I was when I had millions of a viral count of millions</p> <p>MD: You still feel as infectious?</p> <p>I: Hum I feel as if I am</p>	<p>This extract comes from the re-interview series. The account is relevant because the interviewee suggests that his assessment of risk of HIV transmission is the same regardless of viral load numbers.</p>
<p>Thomas re-interview</p> <p>MD: What about and you're undetectable do you think that reduces the chances of transmission what's your philosophy there</p> <p>I: Um I always assume I behave as though it doesn't reduce the chances of I mean I the only thing I suppose I do that is risky is oral sex I don't use a condom for oral sex but um again I reduce the risk in that I would never give or receive oral sex if I have a mouth ulcer or bleeding gums I never ejaculate but you no I am aware that there is always a certain risk involved in that</p>	<p>This extract is from the re-interview series. 'I behave as though' suggests that one has to behave in a certain way regardless of measures of viral load.</p>

Searching for convergence

The extracts in the table below are derived from data categorised as ‘viral load’. They each converge on the belief that while reduced viral load may reduce infectiousness, it does not mean that HIV transmission is unlikely. Such convergence suggests a particular discursive formation of technology and ethics. In particular, these extracts converge on the idea that ‘a virus is a virus’, a paradigmatic form of risk calculus where risk of HIV transmission is absolute and connected with HIV positive identity. These extracts therefore challenge the treatment optimism idea that gay men with HIV are less inclined to do safer sex because they believe treatment makes HIV transmission less likely. The extracts also reveal a post-crisis complexity in risk calculus as absolute forms of risk calculus exist alongside treatment-related, relative ones. Thus the extracts reveal interviewees aware of absolute and relative risk in a technical sense, but preferring an absolute position on risk as a matter of ethical choice. The interview extracts therefore reflect the mixing of technical knowledge and the HIV prevention imperative. As a way of drawing attention to how the ‘viral load’ theme was justified in writing and incorporated into the overall argument, quotations used in the thesis are in bold and page numbers from thesis chapters are provided.

Table Two: Interview extracts converging on ‘a virus is a virus’ with written justification

Extract from interview	Rationale for convergence
Document 'P2N01Rodney' INT1: . . . but touch wood my strain seems to be quite weak. I mean that's just my guess because I've had no symptoms for so long (page 240). MD: So you're quite well at the moment. INT1: At the moment, yes. I've done nothing to deserve that, terrible diet and I drink too much. MD: I see. INT1: No, it's true. MD: So, do you have viral load tests?	'my virus being weak' suggests relative risk 'a virus is a virus' suggests absolute risk calculus Importantly, the interview holds both ideas about risk but seems to 'prefer' an

<p>INT1: Hmm, yes. MD: And what is your, do you know what it is? INT1: I can't remember the number, but – is it 300, 400? It's quite MD: And your CD4 count? INT1: (???) I mean I was speaking to my doctor yesterday who seemed to be quite happy with me. MD: So, knowing about that your virus may be not a very strong one, so it's kind of weak. INT1: Well, that's my guess. But it's still there, you know. MD: Does that change your ideas about how infectious you might be to another man for HIV? INT1: No, no it doesn't. To be honest, the business about my virus being weak is something which I've never actually said aloud before to anyone. It's been in the back there and maybe this conversation's brought it up, but a virus is a virus no matter how potent it is, you know. (page 240) MD: So, it's not a matter of degree, it's there or it's not? INT1: Yes, definitely.</p>	<p>absolute construction as a method of risk management.</p>
<p>Document 'P3N16Peter'</p> <p>M: The final thing around risk stuff is, like, um, undetectable viral load, what you think that means in terms of HIV? R: A thing you just can't see it. I think it lurks there, I don't think it's gone away, I think, you know, wack! If I come off the drugs it's going to shoot back up, and I think...I think 'til we know more about what is going on, and I think it's still very early stages, or a vaccinate cure, you know, it's a word: It's "undetectable" (page 237) it's a word, you can abuse things, and I don't think we want to go down that alley-way. M: Do you think a positive man with undetectable viral load is less infectious than ?? R: No, I don't actually. No. M: 'Cos some people are saying that it is like you are less infectious... R: Well, that's up to them, but it's not how I think (page 243)</p>	<p>This extract uses 'lurks' to signify how treatment reduces viral load and therefore recognises relativism. At the same time, the interviewee does not believe that safer sex is not needed. This extract suggests the adoption of a categorical position of absolute risk. Relative risk is considered but ruled out.</p>
<p>Document 'P2N05David'</p> <p>Yes if you're an undetectable level what does that mean? How undetectable is undetectable? How little HIV do you need in order to infect somebody else? Keep having to say don't know at the moment. Your undetectable is only as good as your last blood test, you know, and that could change at any time (page 238). Um... for all I know it is may change day by day, you know, it just happens to be on the days when you're tested you're undetectable. Who knows, it might be slightly detectable at some stage and then it goes down again. No one gets results of that kind on a day to day, hour by hour basis do they I don't think any more.</p>	<p>This extract suggests that viral variation does happen, but that due to its inherent uncertainty, it is not a viable method of risk management.</p>
<p>Document 'P2N08Tony'</p> <p>WHAT ABOUT SEX? BE GOOD TO LOOK AT LIKE... ONE OF THE EFFECTS OF THE ANTI HIV DRUGS IS LIKE REDUCING VIRAL LOAD AND UNDETECTABILITY OR NEGLIGIBLE VIRAL LOAD. SO HOW DOES THAT RELATE TO RISK? Well I've heard that one before as well and to me it's another load of codswallop. Complete codswallop. I mean that's sort of delusion isn't it? You're saying the viral load is so low that even if body</p>	<p>This extract rejects relative risk in preference for a categorical form of risk assessment. 'Qualifying' is ruled out. Relative risk is constructed as an excuse for not doing</p>

<p>fluid passes you know there's so little of this whatever HIV in it that so what? Even if there's a tiny bit in it maybe it takes a bit longer to grow (page 240)... again it's complete self delusion. I've heard that one so many times as well that my viral load is low therefore my, your chances of picking it up from me are negligible I thought was complete bollocks. It's self delusion, it's just another way of excusing having unsafe sex as well. I don't believe it... I mean I practise unsafe sex but I've never deluded myself with any of these arguments whatsoever (page 240).</p> <p>[later]</p> <p>Well three years ago I might have been, I don't know, I mean things change obviously over the years. I mean certainly in the last eighteen months I take the view that any sort of unsafe sex is risky (page 241) and all of these sort of cop outs, I've got a low viral load or I'm the active or I'm the passive one, I didn't come inside you. You know, all these sort of standard cop outs I just think they're just... (page 242)</p> <p>SO WHAT'S CHANGED THOUGH?</p> <p>Well I suppose I've, well I've obviously read an awful lot and I tend to believe more what I read. You know, unless proven otherwise then unsafe sex is unsafe sex. There's no sort of qualifying it with these other possibilities (page ??). You might as well say the guy looks healthy therefore not very high risk or the guy looks like a beanpole then he is high risk, it's that sort of rather crude way of looking at things (page 241).</p>	<p>safer sex.</p>
<p>Document 'P2N10Kevin ', 1 passages, 730 characters.</p> <p>From again what I understand from speaking to my doctor and from my own reading around the subject it seems that a low viral load in your blood system is no guarantee that there's no HIV in your semen or that there's a similarly low reading of HIV there. And my understanding also is that even if the drugs penetrate your blood stream so as to suppress HIV there that it can be in all sorts of other places, like your brain and lymphatic system. So I don't assume that 'cause I've got a low viral load that I can screw people without risking them (page 242).</p>	<p>In this extract relative risk is also rejected, on the basis of professional advice.</p>
<p>Document 'P2N11Robert'</p> <p>DO YOU THINK THAT MAKES A DIFFERENCE FOR INFECTION? No, no, no. The fact it doesn't show up on a test doesn't mean... OK your viral load might be one but it's still there. I mean if we find a cure for it and you can sort of obliterate it completely then you know maybe, then maybe it's OK I don't know. But at the moment all it means is that the test isn't sensitive enough to show the HIV that's my belief (page 238).</p>	<p>In this extract, relative risk assessment is rejected on the basis of the technical properties of the blood test. It also signals a form of 'until further notice' regarding low viral load and infectiousness.</p>
<p>Document 'P3N15Timothy'</p> <p>Oh, I'm sure it's still the same, even though it's undetectable, it can be given in other parts of the body. It might be undetectable in your blood, but it's still there, it's not like it's gone completely. As they say, it can be hiding in other glands, and stuff in your body. I don't think it makes any difference whether it's undetectable or not. You've still got HIV, you're still positive, and you're still carrying the virus, doesn't mean to say they've killed it off (page 242).</p>	<p>'You've still got HIV' implies a categorical, identity-related form of risk assessment.</p>

William re-interview MD: But um how um your viral load what is that like? I: Undetectable MD: So how does that make you think about oral sex? I: It doesn't make me think that I'm any less infectious MD: Really I: Hum I still think I'm infectious as I was when I had millions of a viral count of millions (page 242) MD: You still feel as infectious? I: Hum I feel as if I am	This extract literally rejects relativism by rejecting the numerical basis of relative risk assessment. In this view, infectiousness is categorical and unchanged by treatment.
Thomas re-interview MD: What about and you're undetectable do you think that reduces the chances of transmission what's your philosophy there I: Um I always assume I behave as though it doesn't reduce the chances (page 242) of I mean I the only thing I suppose I do that is risky is oral sex I don't use a condom for oral sex but um again I reduce the risk in that I would never give or receive oral sex if I have a mouth ulcer or bleeding gums I never ejaculate but you no I am aware that there is always a certain risk involved in that	Similarly, in this extract, an absolute form of risk has preference. A mode of behaviour is adopted 'as if' treatment did not exist or did not reduce HIV transmission risk.

Addressing 'deviant' and contrasting cases

The extracts in the table below show how 'deviant' or contrast cases were analysed. The previous table showed convergence on the absolute risk idea that low viral load does not mean that HIV transmission will not occur. The following extracts are different. They each engage with or admit in some way that HIV transmission is less likely in sexual practice because of low viral load. These extracts therefore contradict the constructions of absolute risk presented in the table above and raise several questions: Do these 'deviant' or contrasting extracts reveal 'treatment optimism'? If they do, does that mean that 'treatment optimism' is relevant for the sexual practice of some gay men with HIV? And if so, how can we explain why interviewees placed such different emphases on viral load and its implications for infectiousness? This dilemma of explanation is acute because it appears that interviews were not divided according to their technical knowledge. For example as with the previous examples, admitting relative risk did not also mean that the interviewees believed that HIV transmission could not occur. Taken together, the contrasting extracts were used to establish the idea of contest over paradigmatic and post-paradigmatic risk

preference, forms of risk management that combined the technical considerations of absolute and relative risk with the ethical considerations of the HIV prevention imperative. As with the convergent extracts, quotations used in the thesis are presented in bold with page reference numbers.

Table Three: Contrasting cases for ‘a virus is a virus with written justification

Extracts	Rationale
<p>Document 'P2N03G'</p> <p>But the fact is that, you know, there’s that part of me that wants to believe that I’m HIV negative now. And that’s what it comes down to. When, if they can’t find any HIV in a blood sample then I don’t have it. And it’s a kind of, a form of denial I suppose in some ways, it’s like I’m cured, you know, it’s – I now have that manageable, controllable illness like diabetes that they’ve all been talking about for these last few years, you know, it’s just something that I just have to keep taking the tablets and I’ll be fine. And I know intellectually that that really isn’t the case yet. It may be, but as I’m sitting here now it really isn’t, and I’m still infectious to a – I would presume to a lesser extent than I was before, but still nonetheless presumably infectious (page 239). That’s the difficult bit, the difficulty is there’s not any research that’s been done in this area really that says, you know, oh well – it’s like, you know, the risks of oral sex, the fact that do people get infected through oral sex. It’s like okay, and now the thing is well do people get infected if your viral load is undetectable. Who knows. But it’s not worth taking the risk that I may infect him just because I think ‘well it’s not likely is it’. But it’s difficult when that man wants to tell me that actually it is okay. It’s that balancing up the emotional response with the intellectual response. And I always manage to, as I say I always manage to vocalise the intellectual response.</p>	<p>This extract is complex because of its reflexive execution. The interviewee talks about the attraction of the idea of low viral load reducing risk of HIV transmission. The prospect of low viral load is described as a struggle between intellectual (technical knowledge) and emotions (ethical responsibilities). This extract is not categorised in the convergent extracts because of this attractive ‘liminal’ quality of relative risk and its relevance for sexual practice. The extract also foregrounds the techno-ethical dilemma faced by gay men with HIV in their sexual practice.</p>
<p>Document 'P2N09Colin'</p> <p>YOU SAID BEFORE THAT YOU KNEW YOUR SEMEN DIDN'T... Yeah, well I did a survey earlier this year... WHO WITH? With... CLINIC DOCTOR? Yeah. And I was part of the control group because I didn't have gonorrhoea (laughs) and he came back and said we can't find any virus in your semen or sperm (page 239 and 251). I was quite shocked actually by that but I have read things in the papers and magazines over the years of being just left in the spleen and the tonsils. So why not just have one's spleen and tonsils out and be done with it!</p>	<p>This extract is distinctive. It reveals a definite acceptance that treatment reduces HIV infectiousness, reflected in low viral load in semen. However, it also shows that the possibility of HIV transmission is also accepted.</p>

<p>[Later]</p> <p>JUST TO SORT OF EXTENDING THIS KIND OF DISCUSSION ABOUT RISK, LOOKING AT YOU KNOW UNDETECTABLE VIRUS, YOU TALKED ABOUT SEMEN AS WELL. WHAT, HOW DO YOU SEE UNDETECTABLE IN TERMS OF IT?</p> <p>I see myself as about infective as a squashed tomato, that's how I see myself. SO YOU DON'T SEE THAT YOU COULD PASS ON HIV?</p> <p>I didn't say it was impossible but I think it's very, very slim the chance. That's what I would like to think anyway (page 239 and 251).</p>	
<p>Document 'P3N14Vincent'</p> <p>R: No, I think, I think by having, I think by having my viral load as low as it is I am not as infectious, but I'm still infectious. So it's just, it is, you know, yes, I'm putting somebody at less risk (page 239), but that's kind of...</p> <p>I: But it's still there?</p> <p>R: It's still there, and that's, you know, you either say, you know, you're HIV positive or you're not HIV positive. And yes, I can... Obviously the viral load makes a difference, but in the scheme of things, you still have to make that decision about whether or not you have, I mean I am HIV positive, then I have to decide whether I have unprotected sex with somebody or not, and I'm very, I... You know, by saying my viral load is low, it's kind of, it's like on the second level of reasoning. You know, you've got to justify the first one, and then, you know, then the second one.</p>	<p>This extract is a contrast case because it seems to give equal weight to both relative and absolute forms of risk assessment.</p> <p>'I'm putting somebody at less risk' reflects risk relativism connected with low viral load with implications for decisions about safer sex.</p> <p>However, 'you're HIV positive or you're not HIV positive' suggests the absolute categories of a paradigmatic form of risk calculus.</p>
<p>Document 'C, Interview 2'</p> <p>I mean there's no kind of, you know, you're either infected or you're not, there is a huge degree of, you know, you can be very badly infected, you can be a bit infected, and, you know, if you alter that ratio I mean the drugs alter it so that you're only a bit infected (page 220 and 237)</p>	<p>'A bit infected' reflects risk relativism connected with low viral load.</p>

Example Two: Exploring the aesthetic qualities of care of the self

Self-care was an important theme of the analysis. Personal engagements with the difficulties and benefits of treatment emerged in the first phase of 25 interviews, even though the interviews were initially focused on HIV prevention in light of treatment and treatment optimism. Self-care is also a prominent aspect of interventions helping people with HIV to use treatment. In addition, the risk governance literature indicated the disciplinary qualities of discourse about self-care in connection with treatment-related uncertainties. Self-care was therefore addressed in more detail in the re-interviews and developed into a major theme.

Comparing and contrasting case studies

The table below contains extracts from each of the case studies used to explore self-care. The case studies were based primarily on the re-interviews of volunteers. However, material from the first interview was also drawn into each case study. Case studies showed that each interviewee adopted methods of self-care oriented to the management of the uncertain qualities of treatment and furthering life expectations. The individual case studies foregrounded the sense of aesthetic unity to accounts of self-care, suggesting how self-governance in post-crisis reflects a “... certain complete achievement of life” (Foucault, 1988: 31). In addition, case studies showed that the aesthetic qualities of personal accounts were not apparent in cross-case thematic analysis, which tends to ‘cut-up’ interviews in the process of developing themes. However, the individual case studies needed to be analysed and summarised in some way, so they needed to be compared and contrasted, as portrayed below. Comparing and contrasting the self-care aspects of the case studies led into a more general notion of the personalised quality of engagements with uncertainty and life expectations. In particular, the thematic analysis suggested that self-care strategies were

formed to extract a positive value from treatment-related uncertainties. However, the movement from case studies to thematic analysis raised a methodological issue to do with the ‘individualising’ of case analysis and the ‘normalising’ of cross-case analysis. A challenge for analysis and presentation therefore concerned maintaining a sense the aesthetic qualities of personal engagements with post-crisis uncertainties and being able to make a general assessment of self-care in the post-crisis situation.

Table six: comparing and contrasting case study material on self-care

Extracts from case studies	Aspects of self-care
<p>Stephen</p> <p>In the 90s, Stephen got an AIDS diagnosis and stopped work. In this context he developed a future plan:</p> <p><i>“then I put the I had my game plan for the future, which was look after myself, I mean this probably means a bit more, is actually take bad use of bad word, positive steps to look after myself as opposed to let my whim look after myself. This is going to the gym . . . “</i> Int 2</p> <p>Stephen also took up self care strategies like diet, rest, relaxation <i>“and be very punctilious about taking my tablets “</i> int 2</p> <p>Stephen returned to the problem of dividing HIV from other body effects: <i>“I am a middle aged man”</i> int 2</p> <p>Stephen uses parent deaths to anchor his biog: seen as <i>“certainties”</i> int 2. The passing of the body has ontological weight.</p> <p>Legal issues come up again: refused entry to US – citizenship under question – see also pension, negotiation of safer sex with partner.</p> <p>Stephen is now in a period of settlement linked to the advent of treatments:</p> <p><i>“and then there was a settlement period where I actually felt comfortable and I realised that I’d got all this sorted out because I wasn’t getting ill I suppose there was a period of equilibrium”</i> int 2</p> <p><i>“I want a settled life”</i> int 2 (settled mentioned 3 times; settlement mentioned 3 times overall). Stephen draws on legal or actuarial terminology.</p> <p>I then ask Stephen a question about his future: <i>”well I don’t really think about it, because my life is I mean you know settled”</i> int 2. I am left unsure what he means. Does he mean settled as in calm and OK. Or does he mean settled as in there is nothing he can do about it.</p> <p>Stephen says that he has always had a plan for his life related to being a</p>	<p>Gaming as an aesthetic orientation to risk</p> <p>Positive steps</p> <p>Dosing Discipline</p> <p>‘Settlement’ as an alternative or contrasting orientation to risk. Implies balance, harmony and therefore post-crisis orthodoxy of medical watershed and improved life expectations</p>

<p>successful person in middle class terms. Stephen sees health as capital (not surprising considering his previous occupation). This leads into a discussion of body care. Stephen wants his body to be: “stronger” int 2 via gym; “look nicer” int2; “more supple and nimble” int 2. Stephen says he needs to rest as: “the machinery’s getting older, it has to be looked after better” int 2. Stephen also links this body maintenance with treatment compliance:</p> <p><i>“and this business of taking tablets, I cannot see the point of rocking in here and smiling sweetly and signing pieces of paper then not fulfilling my side of the bargain “ int 2;</i></p> <p>and then relations with the clinic and divisions of expertise in health care: “the clinic will go on giving me its best advice and I will go on taking the medicine”</p>	<p>cultivating the body and mind</p> <p>Treatment as a contract</p> <p>Division of expertise</p>
<p>Robert</p> <p>Robert was not shocked to be diagnosed. Interview 1 shows that he expected it: “I think in all honesty I probably thought I was positive (int1)</p> <p>He came to the clinic for HIV diagnosis and treatment after a longish period of illness. This suggests that he suspected HIV infection. He did this in November 1998 at the clinic. By May 1999 he was on combination therapy.</p> <p>Interview 1 shows that Robert has changed his mind about the utility of his decision to delay testing based on feedback from a doctor that his illness could be HIV related:</p> <p><i>“I mean I didn’t test until last year because I’d always felt perfectly well and I’d been fit. And I couldn’t quite see the point in testing for something that, well I mean it’s fairly treatable now but going back a few years it wasn’t. I couldn’t see the point. I think I was wrong I think probably I should have tested quite a long time ago. . . . I think the you can be monitored and you can sort of make adjustments to your lifestyle get fit exercise . . . look after yourself, eat sensibly, try and avoid stress. Instead of having HIV ticking away inside of you and just carrying on as before” (int1)</i></p> <p>shows recursive quality to risk assessment and links with changes in treatment</p> <p>Robert resisted treatments for a few months. He had hoped that his immune system could deal with it naturally. So a real milestone was him deciding to relinquish his body to treatments [good to follow this up in relation to the link between treatments and health – treatments as an absolute regime of health restoration – also treatments uptake as momentous in terms of disciplinary regime where HIV treatment management is exchanged for AIDS. ‘Naturally’ means free of intervention. Perhaps treatments means being part of a system that is not natural etc]</p> <p>Robert used to fear HIV:</p> <p><i>“I used to worry about it, I used to have a terrible fear of HIV in the days when there was no effective treatment, um, and then I read an article in, I think it was Positive Nation about a guy who was sort of given 18 months to live with symptomatic HIV, and in response he decided to get very very fit and um you know it sort of told how ten years later he’s still alive and well and he ran a triathlon or something. And it sort of made me realise that there was an alternative, and that sort of alleviated my worry about it” (int2)</i></p>	<p>Implies watershed in risk calculus and connections with self-care</p> <p>Watershed again in connection with fear of what HIV infection means for life expectations</p>

In int 1 I had actually asked him about his future in connection with drugs [ideas re hope and technology emerging at that stage]:

MD: what are your hopes for drugs for the future?

I don't really think about it to be honest. I tend to get on with my life. I make sure I take the drugs when I should do and in the months I've been taking them I've only missed one dose when I wasn't feeling very well. But I tend not to think about it too much. But yeah I should think there are other combinations obviously. Um [pause] Bit I don't sort of sit there worrying or hoping that there'll be a cure 'cause that's not really productive, it's not really helping me.

So where do you see your health going in the future?

Um I think a lot depends on me I think if I keep fit then hopefully I'll be OK. I want to give up smoking though [which he had done by int2] (int1)

Robert's family history project is mentioned again in the context of changes for the better since treatments. This family history is not connected with HIV for B. He puts it down to having time on his hands. [But it is an odd thing to mention in relation to the future – Robert going back in time, or is he resisting my question, or is it the only interesting thing in his life at the moment.]

"I dealt with the diagnosis quite well, but at the same time you know it's something that sort of makes you think. And plus I wasn't happy with the job I was doing and I sort of knew I wanted out of that. But by the same token I wasn't I was quite unsure about what I was going to do long term and how long term was and you know these sort of doubts" (int2)

Robert was not shocked to be diagnosed with HIV. His treatments have improved his health. He is now moving out of recuperation from poor health and considering his future. He is not overly perturbed by treatments, side effects and other aspects of HIV. He has also taken the consumer ethos of health care to its logical extension and shifted clinics to get access to a preferable consultant. But there is sense in which Robert was in a liminal state before he was tested. Diagnosis was a culmination not a crisis. So perhaps it is not difficult to live in another liminal state of treatment uncertainty. There is also a message here about risk management in relation to the course of treatments. But Robert is also very non-committal about most things in the interview, deceptive given his decisive move of clinics. His symptoms and side effects are even reinterpreted in light of his age and what one could expect of ones body. Robert wants to make changes, to get a job, study, move house, remain well and lose weight. But Robert is contradictory. His phrase 'I try to let things wash over me' is apt as it is a key note of his interview approach but also does not refer to HIV in a direct sense. There is a suggestion that Robert is not happy to accept standard medical approaches to HIV. For example, he found the clinician unacceptable so he left. He is handling HIV with a minimum of fuss. He is not happy to have HIV invade every moment and be used as an explanation for his life. [Consider resistance of HIV treatments as a disciplinary regime]. Although he does recognise that there is some doubt about what treatments will provide in the future. Robert's issues are about benefits and employment. Perhaps this is the real reason he did not want to do the bio exercise. It was making too much of HIV for him. And perhaps this is also why he referred to work and his family genealogy so frequently. HIV is not his occupation.

Living with HIV is not a preoccupation – suggests normalisation

Is placing oneself in a family genealogy a way of normalising biography?

Michael

<p>Practices of self care provided ways of resisting -- or Michael resisted HIV thru self-care:</p> <p>“And and all of the side effects of AZT were all the symptoms of AIDS it was like hello you know and you know so I had a really as I saw it healthy dis-trust of the medical profession I went in regularly for my check ups listened to the doctors and they learned very quickly that I was not going to take any of the drugs and um the drug and that was the way it was going to be I was going to be bolshie and basically I did everything I could to inform myself and you know in doing all of that I started to see that I could help myself in lots of other ways and that you know as far I was concerned the way to prevent the onset of AIDS was about living a healthy lifestyle in every way I’d already been you know cut out a lot of the toxins that would cause all the problems cause various problems I was you no I was in recovery and so I was working on lots of mental issues all of my past and clearing all of the garbage out from there and that you know if that was the case why should I get out all of the studies and surveys long term survivors as they were called then people they said could of you know been infected 10 or more years um and obviously at the time they still didn’t think it had started till the early 80s you know it was all of the people that were still alive they had started to collate information as to what they all had in common and so I went for it you know and um it I felt empowered I felt I could do something which a lot of people I knew didn’t and I had a friend who was diagnosed several months after me who within a year and a half was dead and he just he just gave up he was told he was positive and he had exactly the same reaction as I did and thought oh well I’ll be dead in a couple of years I’m just going to smoke a lot and make it manageable make it bearable um and he died (int2)</p> <p>holiday from anti-HIV drugs was supposed to be a ‘cleanser’ – but Michael was betrayed:</p> <p>“Yeah and that was my theory it was that it would be great for my body to have a break I’d go across I’ll be in the sunshine and swim everyday we’ll go for long walks I’ll eat fresh healthy foods you know fresh Mediterranean lifestyle perfect two weeks of that and then back to London do all the other bits and pieces that I would you know just carry on with my life go to the gym maybe have a juicefest have a detox different things like that you know (int2)</p> <p>NB “eradicate HIV” seen as the raison detre of treatments (int 2)</p> <p>also notion of balance is a keynote of working out how to cope with things and treatments (modernism)</p> <p>treatments and self-care joined up, a cooperative approach:</p> <p>“I know the the Lipodstry that I had would have been a lot worse if I hadn’t been doing all the other things because all the other things that I do like my juices in the morning which flush the kidneys and the liver if I didn’t do that then the drugs would be there they’d be clogging up various things it would make a big difference so with the way that I do things I know that I am maintaining my health to the best of my ability and the drugs are maintaining the HIV as a low a level as possible to the best of there ability and I work with that (int 2)</p> <p>Michael’s theory re treatment:</p> <p>“So, you know, it’s a combination of various other factors which actually result in AIDS and illnesses and so on. If you can support your immune system to the best of your ability in all the other areas then you’ve got a better chance of</p>	<p>Informed patient</p> <p>Cleansing</p> <p>Recovery</p> <p>Long-term survivors</p> <p>Mental attitude</p> <p>Treatment holiday – cleansing</p> <p>Detox</p> <p>Balancing</p> <p>Health a combination of treatment and self-care</p> <p>Optimising <i>chance</i> of</p>
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<p>surviving any other illnesses that come along, or even preventing the illnesses from happening in the first place. And that was the viewpoint I took. int 1</p> <p>Self-care</p> <p>Michael does a lot to self manage, Pilates, meditation, avoids alcohol, diet, diet supplements, mitaki:</p> <p>“Well I mean obviously physically I’m doing a lot more physical exercise than I’ve ever done really aside from obviously the drama course a lot of which was physical and there were a lot of movement classes in that um the gym 3 times a week and um I still meditate daily and I do all those kind of things you know um generally still very good with food and healthy eating some supplements although I take less supplements than I use to mainly because I eat mainly organic food now and fruit and veg so I feel that I probably don’t need to be pumping myself full of vitamin C and all the other vitamins because when I’m eating organic food there’s more there’s a better natural supply there anyway – (int2)</p> <p>illnesses have made Michael very angry:</p> <p>“Yeah, yeah well that was it when I came down with the KS you know after what 3 ½ years of working on myself and doing all this stuff I was furious I was outraged that this should happen to me after all of the work I’d put in you know it was like no I was in control here but of course I wasn’t in control but at least I was doing myself some good and I think it would have been a lot worse if I hadn’t</p> <p>NB working on myself</p> <p>combining medicine and self care are no problem, when Michael saw that people were doing well on treatments he was happy to go onto them – he has adopted a eclectic, empirical approach.</p> <p>(Int 1) shows that Michael adopted a self care focus to handle HIV infection:</p> <p>“Because when I was diagnosed, first I chose to ignore it as much as possible until I stopped drinking. And then when I stopped drinking I started to look at how I could support myself in a healthy way really. And so I started to do a lot of research, a lot of reading, and I settled on the side of various magazines, things like Continuum, which were very anti-drug and I’ll just do everything I can to maintain my health with complementary and alternative therapies, anything that I know is not going to do me any harm, and then if God forbid anything really serious happens then I will consider taking drugs. And so I held off for as long as possible . . . (int 1)</p> <p>“Yes. Yes, I mean I talked to them because I had quite a reputation for being very bolshi and very stubborn about my treatments and that. But, you know, I was very well informed and so, you know, it wasn’t the case that they could just fob me off with something, so I think they knew that, and they knew that the way I dealt with it was by being informed and that was my coping mechanism (int 1)</p> <p>awareness of self-deception: “I guess I can kid myself – (int 1)</p>	<p>surviving</p> <p>Changes in daily life</p> <p>Frustration</p> <p>Working on self</p> <p>‘do everything I can’</p> <p>Assertion goes with this method of self-care – have to force a relationship between self-care and medicine, force doctors to take notice and support self-care</p>
<p>Andrew</p> <p>self-preparation to go back onto treatments:</p>	

<p><i>“around May time this year cause I knew because I knew that I would have to go back on to the drugs and I was doing all the investigating myself preparing for it or I was preparing for the worst I suppose probably slapped back on PI’s and thought oh no um but once I got over the hurdle of my own mental hurdle of my attitude changed my attitude has actually changed towards the drugs and HIV is not such an issue for me anymore” int 2</i></p> <p>Life expectancy</p> <p><i>“when I was diagnosed I was given 5 years and I superseded that by one year I’m overdue death by one year” int 2</i></p> <p>also mentioned in int 1 where he said he was “optimistic” int 1</p> <p>MD So how does it make you feel about the future what do you think will happen?</p> <p>what a question to ask um what do I think is going to happen how can anyone answer that question I mean it’s so open-ended int 2</p> <p>Treatments</p> <p>int 1 brief mention of a mistake in treatments</p> <p>meaning of undetectable from interview 1</p> <p><i>Andrew: then I started back on Indinivir then I was told in 97 that my viral load was undetectable</i></p> <p><i>MD: when they told you that, what did that do for you?</i></p> <p><i>Andrew: undetectable</i></p> <p><i>MD:MM</i></p> <p><i>Andrew: pause what did it mean? pause I’ve never been asked that question. I was happy. I was really happy cause I could something to tell my parents actually. Saying I am getting better. Well not . . . I’m not getting better but I’m stabilised, there’s no way I’m going to go over the edge tomorrow . . . it’s not very pleasant when you’re told you’re undetectable but we don’t three ninety cause we can only test down to four hundred. It was five hundred then it came down to four hundred and now its below . . . I will not let this virus beat me. Something will get me probably a heart attack or a stroke. I don’t care, will not die of HIV. I wont have it. (int 1)</i></p> <p>This passage shows how Andrew uses technology to resist HIV but the uncertainties in the technology are a source of frustration. Undetectable makes him happy until further interrogation shows that ‘undetectable’ has been superseded by a finer measure</p> <p>Self-care (int 1) “physically watching myself go down the drain”</p>	<p>Preparing self</p> <p>Future as open-ended</p> <p>Resisting</p> <p>Wasting</p>
<p>Kevin</p> <p><i>The last 12 months: fatigue and self-care</i></p> <p>When asked how the previous 12 months had gone, the first thing Kevin spoke of were side effects such as kidney stones, nausea, muscle wasting, problems with erectile response and questions over subtle changes to appearance of legs – mild lipodystrophy (mentioned in interview 1). Interestingly, not all body issues are reviewed in the clinic, because Kevin manages them himself: <i>“I’ve never bothered even telling [Dr F] about it [dry skin] because it’s very easy to</i></p>	<p>Self-management of illness</p>

<p><i>manage</i>” (INT1).</p> <p>Kevin has experienced a qualified return of energy since his major illness. He is able to work but finds that he is fatigued most of the time. Exercise is the recommended therapy but doing exercise brings up contentious issues for self care. He has been attending a Healthy Life Programme for people with HIV at a gym. But has found that the social distance between him and his (non-gay) carer at the gym has created problems. Also, his massage therapist has missed appointments, leading to frustrations.</p> <p>Kevin also notes how difficult it is for someone with low energy to coordinate all these agencies and deal with negative emotions. Depression emerges in this part of the interview, linked with running out of energy but also with the efforts at trying to overcome it. It is noteworthy how the ‘treatment’ (in this case self-care embodied as exercise) becomes the disease (stress, alienation, isolation).</p> <p>In response to all this, Kevin has developed a mode of self-preservation: “<i>I’ve learned to be a great conservator . . .</i>” (INT2). For this he draws on experiences in psychotherapy: “<i>I’ve acquired some kind of subconscious technique</i>” (INT2). Kevin’s techniques include: distractions, reinforcing ‘easy’ achievable acts, ‘balancing’ his psychology, being aware of negative thoughts, re-thinking social relationships, leaving too hard things to one side, avoiding HIV support groups!!!! (because he has been let down by support group initiatives). Prefers to seek out informal support.</p> <p>Kevin has also begun to restrict going out to avoid alcohol and cigarette smoke (NB allergy linked to nevirapine, so that the drugs are directly linked with a more restricted social life). Need to consider the extent to which these increasing restrictions fuel or are fuelled by the emotional impact of HIV disease and treatment – depression.</p> <p>There is a sense of Kevin containing/controlling fatigue, normalising it in his life. This is both work on the body and on HIV. There is a striking passage about the management of fatigue, where the body is spoken of as a possession: “<i>Your body is dealing with the virus . . .</i>” (INT2). There is also an aetiology for fatigue according to DR P. There is the effect of viral activity on the body and then there are the effects of ‘toxic’ drugs on the immune system. Kevin calls this a “<i>melange</i>” (INT2). Kevin also traces his ‘fatigue’ back to his illness with pneumonia, something he calls the “<i>body blow</i>” (INT2). Since the body blow he has never been quite the same. There are many questions here about material effects of/for change, perception, sensitivity, passage onto retrovirals There is also a question whether for Kevin, fatigue represents AIDS made over by anti-retrovirals. Health is not so much about managing HIV as about managing fatigue. Fatigue is emblematic of the new HIV disease melange of body, treatments and self-care.</p> <p>There is also an issue of legitimacy. Kevin is aware that his problems (side effects, support etc) are “<i>not particularly severe</i>” (INT2) Dr F said “<i>you’re not in that capacity</i>” meaning you’re not dying. Dr F dealt with him as so: “<i>look there are plenty of people worse off than you, why don’t you just live with this. And it was like that about lipodystrophy and erections</i>”. (also KS lesion) Kevin is caught up in issues of legitimacy and subjectivity, between the severity of his hospitalisation with his ongoing health issues, between acute vs chronic. For Kevin his physical experiences and emotions are hard to make objective in discourse about HIV treatment: “<i>They’re something that I feel and only I can give evidence to. And all you’ve got is my oral evidence about how I feel. And since I usually look great, um, people don’t understand why I don’t feel great</i>” (INT2). For example: “<i>somebody in your position 10 years ago or 5 years ago</i></p>	<p>conservator</p> <p>Changes in daily life</p> <p>Defining important illness</p>
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would have died, you look great . . . they can't see for themselves what's wrong. You sound like you're moaning" (INT2). Kevin reckons people want to believe that AIDS is over: "People don't seem to understand, maybe there's a kind of headline mentality or spin doctor mentality here, they seem to think that combination therapy represents some kind of cure. Well they don't understand that combination therapies fail. They can have very damaging side effects. They're a complete bloody nuisance in your life. And they can't reverse all the effects of having been infected by HIV . . . mental thing of knowing that you are chronically ill . . . that its irreversible and that it fucks up your sex life" (INT1)

These are important issues of ontology, objectivity, subjectivity, legitimacy. Kevin feels that he has to be careful about expressing what he feels because they may not take him seriously "I get pissed off about it" (INT2). This isolation is one of the horrors of chronic disease or chronic pain (see Bendelow).

Kevin reckons that the crisis and these social effects have lead to/required emotional changes: "now I've changed – a bit more patience" (INT2). These experiences were seen to flow into and out of his conservator style of self-care. A particular experience with another health scare showed that Kevin had 'changed'. In late 97 he noticed a KS lesion on his abdomen. Kevin was very fearful of KS, a fear that can be traced back to visiting a friend in New York, with severe lesions (INT1). There was also a tension with Dr F re excision vs treatment. Kevin wanted the lesion cut off his body. Dr F advised waiting, as it was likely that the antivirals would deal with it. This tension reveals something about the way treatments can be used to subdue. The treatments make it possible (advisable) to wait, rather than to use a surgical procedure. So Kevin was required to wait. There was also a suggestion of homophobia. Kevin justified his fear of KS, partly as the lesion would be visible if he took his shirt off in a night-club. But Dr F had an opinion about that as well drawn from a very odd epidemiology: "She said a third of the people in the Fridge has got KS, I wouldn't worry" (INT2) Kevin was quite taken aback. This is the same Dr who was ambivalent re treatment about erectile response. There is a sense in which the treatments are used to pacify, but that operations on sexual practice are marked off: dealt with by deletion (need to build up connections between treatment management and sexual practice).

The KS experience was emblematic of the emotional changes Kevin has experienced: "now if you'd have said that I could have dealt with a possible cancer diagnosis with phlegmatism in any period prior to this period I'd have said no, I wouldn't be able to do that, I would you know, I'm a bit hyper about things and I'd probably have reacted very very negatively to it, and with a lot of emotion, But in fact I didn't even tell people . . . A change occurs here at some point (he says pointing to his chart). Partly it's forced on you because you're too tired to be anxious and angry about stuff. And it uses up far too much of your energy to be annoyed and worn out and pissed off" (INT2) For Kevin psychotherapy has been useful in this process of adjustment. But I think this is also a form of compliance. Anti-HIV treatments require compliance, not in the minimal sense of regulation of dose, but in the more profound sense of the regulation of patient-hood. The pacification of fears, anxieties, anger about the HIV illness melange are all implicated in the self-disciplinary regime of patient-hood.

In the context of his treatment biography, Kevin returned to the issue of lack of energy. He wrote down a medical term for this problem of energy that Kevin noted from a consultation: lassitude. Kevin found this term pompous. The Oxford definition is languor or disinclination to exert oneself. Thus lassitude is made possible by successful treatment but foregrounds the conduct of the patient. In so doing, conduct is exchanged for AIDS.

Patience

Managing negative emotion

Fatigue

<p>Kevin provides a picture of conserving/disciplining the self in face of the long haul of treatment viability. It is worth considering to what extent are the management of anti-HIV treatments predicated on the notion of the perfect patient or the perfect treatments (see Baudrillard and the cultural effects of the notion of seamless, 'cold', perfectible technology and the abeyance of sociality created in the portrayal of the Apollo moon landing). Consider the social uses of technologies to pacify and regulate individuals to create compliant subjects. These observations do not support Treichler's ideas of radicalised democratic technoculture. The tone is more consistent with Watney's ideas of provisional hope.</p>	Conserving/disciplining
<p>For the future, Kevin says that for him: <i>"it's a sort of jog-along, um, future right now tend to have abandoned great plans"</i> (INT2). He notes that he is not going to buy a bigger house, or strive to become chief executive. This appears to be different to what he said in interview 1: <i>"well what I would like . . . what I wanted to do and what I'm still aiming to do in a sense is to continue my career"</i> (INT1). The contrast in these passages is a changed intent. The passage from int 1 does contain a question of whether all career advancement is possible: <i>"I don't think I'm heart and soul committed to it . . . I thought everything was cut and dry and now it isn't because there's one overriding thing which can intervene and change everything, namely my health . . . and the first thing that could happen is the drug therapies could begin to fail, but on past evidence there's no reason why that should happen. It may be that with the passage of time all drug therapies fail, I don't know . . . I might well find that I live with this chronic sexually transmitted illness for a substantial period of time and that this period may well be punctuated by periods of ill health . . . I don't feel that I'm terminally ill"</i> (INT1). Kevin used an interesting phrase in int 1 to characterise himself and his social relationships in the context of HIV diagnosis: <i>"I've got this fragility"</i> (INT1). HIV disease has become a 'potential' rather than an actuality. By interview 2, Kevin had clearly relinquished his ambition for the sake of his health and appears a little worn down by self-care.</p>	Reining in of self
<p>Kevin is wary of overextending. J's conservation stance is bracketed by possibility of cure brought about by the technologies. Kevin also says that the ways in which he has reined in his life prospects is seen as <i>"relief"</i> (INT1). He has also considered retiring but is not sure what else he would do. This is certainly not the ambitious, testy success of the past: <i>"in the back of my mind there was the notion that maybe I will be dead in three years, you know, so who cares whether I should be chief executive . . . so really I take each day as it comes and I you know, whatever I can take out of my life I enjoy"</i> (INT2)</p>	Need to have personal resources in case treatment fails
<p>Kevin said he had enjoyed the interview. He doesn't talk to many people about these things! His final thoughts were that we are: <i>"all on new territory - treatments changed us from 'basket cases' to potential basket cases"</i> (INT2). This latent risk of annihilation that resides within the uncertainties of treatments energises disciplinary powers of the clinic to create a compliant subject. And for Kevin, given his physical experiences, this compliance resolves into a kind of vigilant, resigned, not too obvious and therefore private, conservatorship of his life on treatments.</p>	Fragility

Searching for convergence

The table below shows how the case studies and interview accounts were used to develop the thematic categories for the different orientations to caring for the self (gaming, positioning, conserving, settling). The different orientations to self-care seemed to share an underlying objective of extracting positive value from treatment-related uncertainty. Interviewees seemed to focus on constructing ways of life that would optimise the benefits of treatment and therefore life expectations. The post-crisis situation for gay men with HIV therefore emerges as one where treatment uncertainty is important to reflexive biography. Moreover, it seems that one method of dealing with such uncertainty is to split it or re-define it, so that it can also be a source of hope. Analysis showed that these orientations could be quite personalised, reflecting the case studies, but also, it is suggested, the personalisation of the challenge of living in post-crisis. However, some interviewees seemed to draw on more than one self-care orientation. In addition, some orientations appeared to be employed by more than one interviewee. Post-crisis therefore implies aesthetic choices of focusing and combining self-care strategies.

Table seven: Interview extracts supporting personal self-care strategies

Extracts	Orientation to self-care
Stephen: . . . Then I developed full blown AIDS, or it was announced to me that I had full blown AIDS as opposed to being merely HIV positive. Then I jacked work because I thought I was going to drop dead within eighteen months, I felt so awful. Then I assessed what was this is, we're now getting to a much shorter timeframe here. Then I assessed the prognosis and the ramifications of the situation I was facing here. We go through the edge of the ellipse, although not the elliptical edge. Then I put, then I had my game plan for the future, which was look after myself, I mean this probably means a bit more, is actually take bad use of bad word, positive steps to look after myself as opposed to let my whim look after myself. This is going to the gym (page 154) MD: WHEN YOU SAID POSITIVE STEPS, WHAT WERE THEY? Stephen: Well, go to the gym, cut out horrendously, foods that were horrendously bad for me, you know, I mean actually take some . . . oh salt's bad for you or E numbers are bad for you or whatever, actually kind of think well maybe, you know, I should cut down a tiny bit without going berserk. So I actually took positive steps to look after	Gaming

<p>myself. I made sure I was getting enough rest, or sleep, whichever you want to call it, and relaxation, so as not to feel pressure which is one of the major causes of problems. And especially, I mean you know, let's be frank here, I am a middle aged man, I am at the age when people get heart attacks through stress and ... (Stephen: 2)</p>	
<p>Michael: "So, you know, it's a combination of various other factors which actually result in AIDS and illnesses and so on. If you can support your immune system to the best of your ability in all the other areas then you've got a better chance of surviving any other illnesses that come along, or even preventing the illnesses from happening in the first place. And that was the viewpoint I took (Michael: 1)</p> <p>Michael: "And and all of the side effects of AZT were all the symptoms of AIDS it was like hello you know and you know so I had a really as I saw it healthy dis-trust of the medical profession I went in regularly for my check ups listened to the doctors and they learned very quickly that I was not going to take any of the drugs and um the drug and that was the way it was going to be I was going to be bolshie and basically I did everything I could to inform myself and you know in doing all of that I started to see that I could help myself in lots of other ways and that you know as far I was concerned the way to prevent the onset of AIDS was about living a healthy lifestyle in every way I'd already been you know cut out a lot of the toxins that would cause all the problems cause various problems I was you no I was in recovery and so I was working on lots of mental issues all of my past and clearing all of the garbage out (page 155) from there and that you know if that was the case why should I get out all of the studies and surveys long term survivors as they were called then people they said could of you know been infected 10 or more years um and obviously at the time they still didn't think it had started till the early 80s you know it was all of the people that were still alive they had started to collate information as to what they all had in common and so I went for it you know and um it I felt empowered I felt I could do something which a lot of people I knew didn't and I had a friend who was diagnosed several months after me who within a year and a half was dead (page 155) and he just he just gave up he was told he was positive and he had exactly the same reaction as I did and thought oh well I'll be dead in a couple of years I'm just going to smoke a lot and make it manageable make it bearable um and he died (Michael: 2)</p> <p>Andrew: . . . around May time this year cause I knew because I knew that I would have to go back on to the drugs and I was doing all the investigating myself preparing for it or I was preparing for the worst I suppose probably slapped back on PI's and thought oh no um but once I got over the hurdle of my own mental hurdle of my attitude changed my attitude has actually changed towards the drugs and HIV is not such an issue for me anymore (page 156) (Andrew: 2)</p>	<p>Positioning preparing/ stocking up</p>
<p>Kevin: And then I suddenly realised that actually when you're HIV positive it isn't a case of your friends run around and help you, you have to help them cope with the fact that you're HIV positive. And if you accept that role, you see and years ago I'd have told people I don't think you're bloody doing this right at all, you're not helping me out. But now I've changed, and in fact I've a bit more patience with people, I'm a bit more circumspect (page 156), and I notice much more effective ways of dealing with them and of dealing with their reactions to me (Kevin: 2).</p> <p>I think the real issue is that if you, if all this is left to the patient himself or herself and the patient has low energy levels it's really quite hard to put it all in place. I also find that if I run out of energy I become depressed. So I've learned to be a great conservator (page 156), a great, you know, energy conservationist, and I know when my energy is slipping away, I keep a careful eye on it now and I don't press on things which could upset me, stress me out or wear me down. I just don't do it. (Kevin: 2)</p> <p>I become grim, sometimes I cry. I get, I get maudlin, I tend to think a lot of other negative things, I can see there's something and I stop it. I can't explain quite how I stop it because this resulted from being in therapy for about three years. I have acquired</p>	<p>Conserving</p>

some kind of subconscious technique (page 156), and its only visible manifestation I can see is that I'm aware that at some point we're slipping into depression, let's just stop this for the moment, let's go and do something easily achievable, like the ironing or tidy your bedroom or go to Wales for the weekend or whatever. And then I'll set myself one of those **easily achievable targets** and I'll do it, and that will begin to restore my kind of **psychic balance** (page 156) as it were. Or psychological balances perhaps. Because you, one of the problems I think when I'm tired and I can't make things work is that I feel a bit of a failure that I can't make them happen (Kevin: 2)

Now if you'd have said that I could have dealt with a possible cancer diagnosis with **phlegmatism** in any period prior to this period I'd have said no, I wouldn't be able to do that. I would, you know, I'm a bit hyper about things and I'd probably have reacted very very negatively to it, and with a lot of emotion. But in fact I didn't even tell people

MD SO IT FEELS LIKE YOU SHIFT GEAR, THE ONE BIG, THIS BIG EVENT.

Kevin: Yes, that's right.

MD YOU SHIFT GEAR ON THE KIND OF ...

Kevin: A change occurs here at some point. Partly it's forced on you because you're too tired to be anxious and angry about stuff. And it uses up far too much of your energy to be annoyed and worn out and pissed off (page 157) and depressed and all the rest of it. And after a while you think well maybe that wasn't the best way to deal with things anyway. And so from being a comparatively emotional person and I suppose there is the thing, I should mention that during this period here of course I was in therapy, and I'm sure that that also since he'd sorted quite a lot out in my mind for me, um, must have contributed to the kind of balanced way in which I dealt with most of these things
(Kevin: 2).

I was always effective, I was not very efficient. And as a result of reduced energy levels I've now become a **much more efficient person** So I both get things done and I make sure that I expend as little energy into it as humanly possible (page 157) (Kevin: 2).

It's a sort of jog-along, um, future right now. I tend, I have abandoned great plans (page 157) (Kevin: 2)

... in the back of my mind there was the notion that maybe I will be dead in three years and, you know, So really I take each day as it comes and I, you know, whatever I can take out of my life I enjoy (page 157).

MD YES. OKAY, WELL THANK YOU VERY MUCH FOR THAT, IT'S BEEN NEARLY TWO HOURS. HOW DID YOU FIND THE INTERVIEW AND THE SORT OF THINGS WE DID?

G I enjoyed it, I think it's interesting to have a chance to talk about it because I don't as you'll have gathered I don't talk about it to many people very much. And I don't talk about my feelings about it to people very much, so it's quite interesting to have a chance to do that.

MD OKAY. IS THERE ANYTHING ELSE THAT WE NEED TO KNOW?

G No. No, it's just I think the whole question of HIV treatment and what helps HIV positive patients, um, is in such a state of flux now because instead of being basket cases they've all become people carrying the potential to be a basket case but who can go straight back into life. And I don't know of any other illness where we have any kind of parallel learning that we could transfer over about how people are meant to cope with that. And so I think we're all on new territory, and it's pretty tough territory (page 157) (Kevin: 2)

And secondly they're much happier if I say, God I feel great and things are going really well than if I say, do you know I'm sick of having diarrhoea half an hour after every dose of DDI and I would really like to have a stop in my life. Or er... I don't want to go out tonight because I've just taking my Indinivir and I feel sick.

And I know that if I'm going to be in this condition and I pop an E later on I would be sick. People don't want to hear that because it reminds them that I've got this fragility (page 157). I mean I can see that people are desperately concerned I might actually pop my clogs at some point and they don't want to have to deal with that. I mean I don't particularly want to deal with it either. But it is hard to raise the issue frankly without reminding them. (Kevin: 1)	
<p>Stephen: And then there was just the kind of settlement period where I actually felt comfortable and I realised that I'd got all this sorted out because I wasn't getting ill (page 158), and therefore I'd done I mean okay, you know, you feel sorry for yourself for 24 hours, then you spend 48 hours working out what you're going to do with it, and the chrysalis opens and there you are, I mean it's not a new person, that would be nonsense, but I'm still the same person which is why I'm now sitting making a list for you. Then there's a little settlement period where, um, I suppose that was, it's not really equanimity, it's equable-ness but I don't know what the real work for that is.</p> <p>MD EQUILIBRIUM?</p> <p>C Yes, I suppose there was a period of equilibrium (page 158) where I was actually not worried that I was going to be roughed around on the financial front (Stephen: 2)</p> <p>No more financial hassles, you know - I mean this is stating the obvious I want a settled life (page 158) where I don't have worries, I'm the person who takes all the decisions about what I'm going to do and what is going to happen to me, I'm a complete control freak (Stephen: 2)</p> <p>MD IT'S JUST HOW YOU'RE FEELING ABOUT YOUR HEALTH AND HOW YOU SEE IT PANNING OUT IN THE FUTURE.</p> <p>Stephen: Well I don't really think about it, because my life is, I mean, you know, settled (page 158) is the word I'd hesitate to use, especially being alleged. But, you know, past my, past halfway through now, three scores years and ten. You know, we're well past halfway through that (Stephen: 2)</p> <p>Andrew: More centred</p> <p>MD: More centred</p> <p>Andrew: Hum I would have said content</p> <p>MD: Ugh hum what do you mean centred?</p> <p>Andrew: Um I'm calmer (page 158)</p> <p>MD: Hum</p> <p>Andrew: Less fanatic I have my moments of panic about every ... oh my god oh shit you no those kind of things escalate beyond belief and then suddenly the next step it's all over I've dealt with it</p> <p>MD: Ugh hum</p> <p>Andrew: Don't let it get on top of me deal with it now and then it's fine (Andrew: 2)</p>	Settling

Addressing 'deviant' or contrast cases

As with other aspects of the analysis, 'deviant' or contrast cases also emerged in analysis of self-care. The accounts in the table below seem to support an orthodox construction of post-crisis as medical watershed and therefore the normalisation of HIV illness. They therefore

contradict the previous extracts which converged on the dual quality of treatment uncertainty. In the contrasting accounts, the reflexive management of self with HIV was not exceptional. These accounts therefore suggest that the aesthetics of self-care in post-crisis includes (but is not exclusive to) the option of an orthodox ‘normalisation’.

Table eight: contrasting interview extracts about self-care

Extract	
<p>Robert: I’m quite adjusted to HIV, so I’m not crying. I mean I had an ex-partner who used to go out night-clubbing, do an ecstasy tablet, come home and when the E had worn off he’d start crying, oh I’ve got HIV. You know, I just haven’t got that, it’s not in me to do that. Um. I try to let things wash over me You know, yes things do get me down sometimes, um, but I think I’m okay really.</p> <p>MD: OKAY?</p> <p>Robert: Yeah, I think, you know, I’m doing all right (pages 159) (Robert: 2)</p> <p>Robert: What else. And I’m sort of more disciplined about doing exercise. But, you know, you should be anyway really, so I feel good after I’ve done exercise.</p> <p>MD: BUT HAVE YOU SORT OF INSTITUTED THESE PRACTICES BECAUSE OF HIV OR ...</p> <p>Robert: Yeah, initially it was because of HIV I think, but it’s sort of become a routine if you like, sort of, you know, sort of a way of life really. So I’m not sort of conscious, I’m not thinking oh I must go to the swimming pool to exercise because of my HIV, you know, I’m not really very conscious of it. And people say the drugs are a constant reminder, I don’t think so. I mean I take vitamins every morning, you know, and you don’t really think about it do you, what you’re taking and why (page 158). Um.</p> <p>Andrew: Don’t let it get on top of me deal with it now and then it’s fine (page 158)</p> <p>MD: What you haven’t written HIV or AIDS here, why which is interesting so like why?</p> <p>Andrew: It didn’t enter my head</p> <p>MD: Yeah</p> <p>Andrew: It doesn’t enter my head nowadays</p> <p>MD: Is that because the drugs are so good?</p> <p>Andrew: No it’s cause I’m sick and tired of living and breathing it every minute of the day sick of having discussion groups of HIV and well that’s that they don’t no how to live well get of the planet right now so that’s me being kind of vindictive and nasty</p> <p>MD: You were saying like that HIV isn’t as important isn’t so central</p> <p>Andrew: No</p> <p>MD: And it’s not so much the drugs is like the kind of</p> <p>Andrew: I think I’ve grown into it</p> <p>MD: Hum</p> <p>Andrew: Have you had that before?</p> <p>MD: No, not grown into it</p> <p>Andrew: I’d say I’ve got use to it (page 158)</p> <p>MD: So when you know I ring you up and say come and talk about it I mean you have to come to the clinic how does that make you feel?</p> <p>Andrew: I’m one of these rare beings I actually like this clinic is odd that isn’t it</p>	Normalising

APPENDIX FIVE: THEMATIC FRAMEWORK FOR FIRST 25 INTERVIEWS

Clinic history-experience

Living with treatments

- Side effects
- HIV tests and the body
- decision-making
- treatment changes
- adherence
- care-roles and responsibilities
- normalising of health
- felthealth versus statshealth
- expectations of treatment
- hope
- well-being
 - self-destruction ??
 - embedded fears
 - depression

HIV story

- HIV infection and testing
- Reactions to diagnoses
- Reactions of others
- Adjusting to diagnoses
 - employment
 - impact of illness
 - diagnoses and safer sex
 - changes in sex drive
 - resisting the virus ??

Sexual lifestyle-partners

- casual sex
- regular partner(s)

Risky sexual episode

- Describing setting and process
 - Negative regular partner
 - bareback
 - choosing uai
 - requests for UAI condom
 - progression
 - nonverbal
- Explanations/mitigations
 - feeling-desire
 - natural quality of sex
 - safer sex as struggle
 - other let me down
 - relational aspects

- self destruction in the other
- thrill
- broken condom
- drugs
- HIV serostatus
 - attribution of serostatus
- Risk reduction methods
- Self protection

Disclosure

- to family
- to regular partner
- to casual partner
- others disclose to intvee
- unintended disclosure
- for finding HIV+ partner
- keep it a secret
- Rejection, unwanted sympathy etc
- when a one nite stand gets serious
- minimising HIV identity
- to not tell is to deceive
- and social support
- intimacy and anal sex
- protection from blame
- enabling risk management

Treatment-related risk beliefs and practices

- risk and treatments
- viral load
- reinfection, resistance & strains
- safer sex & chance of infection
- risk assessments in sex
- scaling risks
- HIV test as categorical
- Risk with a positive partner
- Use of condoms
- other risks & diseases

Issues and ideas for intervention

- 'responsibility' in safer sex
- complacency
- accept risks
- groupwork
- media
- freedom to choose
- people should know
- doctors advice
- experience with sex talk
- HIV diagnosis and sex

counselling
psychosexual
legal
appearance

STIs

STIs as risks
STI infection experiences
STIs/checkups~
treatment experiences

Social network

Use of services

APPENDIX SIX: THEMATIC FRAMEWORK FOR ELEVEN RE-INTERVIEWS

biography exercise

- doing the exercise
- timeline

last 12 months

- sum up of last 12 months
- events of last 12
- recall of previous interview

interview debrief

sexual practice

- sex with HIV positive BF & guys
- sex with HIV negative guys
- barebacking
- sex with HIV negative BF
- sex & infectivity & reinfection
- sex & the body
- sex & 'sites'
- responsibility & 'positions' & status
- disclosure
- anal sex & condoms

treatments, viral load, monitoring

- diagnosis & self diagnosis
- monitoring & stats health
- changes in health
- going onto treatments
- not on treatment
- taking drugs
- coming off treatments
- reinfection beliefs

temporality, expectations, health

- death sentence in the past
- 'chronic disease'
- prophecy + other people
- treatment expectations
- life expectations
- hopes for the future

care of the self

- work, finances, living situ
- gym diet smoking drugs
- wellbeing
- body changes & appearance

dealing with HIV, fatigue
dissolving of aids
self clinic administrating care

techniques for living with risk

settlement & stable & steady & balance
fate, risk, games, bets
'conservator'
minimising

THT ad

prevention and cure

language use and HIV

HIV as qualifier of identity
HIV as possession
slip of the tongue

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